MEDICAID
BUDGET DOCUMENT

State Fiscal Year 2007

The Office of Vermont Health Access

The Vermont Agency of Human Services

OVHA's Mission Statement

- To assist beneficiaries in accessing clinically appropriate health services.
- To administer Vermont's public health insurance system efficiently and effectively.
- To collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.

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Section 1: Contact Information

Office of Vermont Health Access (OVHA)
www.ovha.state.vt.us

Director
Joshua Slen
Email: joshuas@ahs.state.vt.us

Deputy Directors
Ann Rugg
Email: annr@ahs.state.vt.us

Legislative Liaison
Stephanie Beck
Email: stephanb@ahs.state.vt.us

Nancy Clermont
Email: nancycl@ahs.state.vt.us

Address
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Main Telephone Number
802-879-5900

Main Fax Number
802-879-5919

Section 2: Fast Facts

- The Governor's recommend for SFY '07 is $673,863,426
- State of Vermont's largest single programmatic expenditure

  12 Enrollment/Eligibility Groups ~ Aged, Blind and Disabled (ABD); Families; Ladies First; SCHIP; Underinsured Children; Caretakers; Vermont Health Access Plan (VHAP); VHAP-Pharmacy; VScript; VScript Expanded, Healthy Vermonters, and VPharm.

  8 Programs ~ Traditional Medicaid, Dr. Dynasaur, Vermont Health Access Plan (VHAP), VHAP-Pharmacy, VScript, VScript Expanded, Healthy Vermonters and VPharm

  88 Employees in SFY '07 as specified in Governor's Recommend ~ see Appendix 5 for Organizational Chart
- Largest insurer in Vermont

  1st ~ Dollars spent

  2nd ~ Number of covered lives
- 155,768 covered lives in Vermont's publicly funded health insurance programs
- Pays some or all of the health care costs for 25% of Vermont's population
- 60,144 children receive their health care coverage through OVHA in Vermont (2007 projection)
- 9,000 enrolled providers
- 9 million claims processed annually
- 98.6% of all claims are processed within 30 days, with the average time from claim receipt to provider payment of nine days
- Member services averages close to 20,422 calls a month, about 1,123 a day; all calls are picked up by the automatic answerer within 25 seconds and answered by a live person within 2 minutes 90% of the time
- The health care industry is a nearly $4 billion dollar industry in Vermont. Vermont Medicaid represents fully 16.8% of the spending in that system.

Section 3: Program Descriptions

The Office of Vermont Health Access (OVHA) provides medical assistance to 155,768 persons. Individuals are eligible under traditional Medicaid regulations and under a number of expanded programs listed below.

Traditional Medicaid

The *Traditional Medicaid* population includes those who are eligible under the Medicaid rules in Title XIX of the Social Security Act. This population includes the Aged (age 65 or over) Blind, and Disabled [ABD] enrollment/eligibility group.

Aged, Blind and Disabled

Year	Caseload	Expenditures
SFY '04 Actual	23,083	145,321,331
SFY '05 Actual	23,643	161,792,698
SFY '06 Budget Adjustment	24,305	177,566,989
SFY '06 Budget Adjustment w/MMA	24,305	153,615,924
SFY '07 Gov. Rec. w/MMA	***24,797***	138,248,234

The *Families* population includes the Reach Up financial assistance related group: children; their parents or caretaker relatives; and pregnant women.

Families

Year	Caseload	Expenditures
SFY '04 Actual	67,690	126,008,998
SFY '05 Actual	67,719	142,207,467
SFY '06 Budget Adjustment	67,288	148,628,426
SFY '07 Gov. Rec.	***66,990***	155,623,129

The Aged, Blind, and Disabled groups or Families groups can include people who are "medically needy" according to Medicaid rules (they meet other criteria, but they must also spend a portion of their income or resources on health care to become eligible). All Medicaid individuals must meet certain eligibility tests, such as income and resources. Unless individuals meet certain exemption criteria, they must enroll in Primary Care Plus, the state's primary care case management program, as their benefit delivery system.

The *Ladies First* program is for women under age 65 who have been diagnosed with breast or cervical cancer through the national screening program, are uninsured, and otherwise not eligible for Medicaid.

Ladies First

Year	Caseload	Expenditures
SFY '04 Actual	40	516,741
SFY '05 Actual	64	653,877
SFY '06 Budget Adjustment	66	1,317,334
SFY '07 Gov. Rec.	***61***	1,076,904

Note: The ABD annual enrollment data and per member per month (PMPM) costs for SFY '99 through '07 are exhibited on page 12. The families annual enrollment data and per member per month (PMPM) costs for SFY '99 through '07 are exhibited on page 13. The Ladies First annual enrollment data and per member per month (PMPM) costs for SFY '02 through '07 are exhibited on page 14.

Dr. Dynasaur

The *Dr. Dynasaur* program provides health care for children under age 18 not eligible for traditional Medicaid with family incomes up to 300% of the Federal Poverty Level (FPL) and for pregnant women with incomes up to 200% of the FPL. This includes the following two groups in addition to some of the children represented in the preceding families group.

The *State Children's Health Insurance Program* (SCHIP) is for uninsured children who are eligible under the SCHIP eligibility rules in Title XXI of the Social Security Act.

SCHIP

Year	Caseload	Expenditures
SFY '04 Actual	2,924	3,607,885
SFY '05 Actual	3,141	4,145,623
SFY '06 Budget Adjustment	3,125	4,181,625
SFY '07 Gov. Rec.	***3,395***	4,940,365

Underinsured children are those eligible for Medicaid through an 1115 waiver to Title XIX.

Underinsured

Year	Caseload	Expenditures
SFY '04 Actual	1,842	1,141,586
SFY '05 Actual	1,766	1,196,600
SFY '06 Budget Adjustment	1,972	1,627,847
SFY '07 Gov. Rec.	***1,941***	1,783,701

Individuals may qualify for Dr. Dynasaur even if they work or have other health insurance. Members may have to pay a premium.

Note: The SCHIP annual enrollment data and per member per month (PMPM) costs for SFY '99 through '07 are exhibited on page 15. The underinsured children's annual enrollment data and per member per month (PMPM) costs for SFY '99 through '07 are exhibited on page 16.

The Vermont Health Access Plan (VHAP)

The *VHAP* program was designed as part of an 1115 waiver to Title XIX of the Social Security Act to provide health care coverage for adults who would otherwise be uninsured or underinsured. This population includes:

- VHAP adults with incomes up to 150% of the FPL and
- Caretakers who are parents and/or caretaker relatives with incomes from 150% up to 185% of the FPL (including individuals enrolled in ESI – see Section 7).

Caretakers

Year	Caseload	Expenditures
SFY '04 Actual	2,590	3,941,420
SFY '05 Actual	2,376	4,853,340
SFY '06 Budget Adjustment	2,397	5,699,874
SFY '07 Gov. Rec.	***2,476***	6,405,610

Members may have to pay a premium, and co-payments are required for some services. Members are to enroll in a managed health care plan, which is currently the state's primary care case management program, Primary Care Plus.

VHAP

Year	Caseload	Expenditures
SFY '04 Actual	21,739	55,500,942
SFY '05 Actual	22,081	73,431,832
SFY '06 Budget Adjustment	21,953	67,547,625
SFY '07 Gov. Rec. w/o ESI	21,519	77,951,286
SFY '07 Gov. Rec. w/ESI	***28,015****	73,929,917

* This caseload amount includes 6,496 beneficiaries included in the employer sponsored insurance program. For a description of that program please see Section 7.

Note: The Caretakers annual enrollment data and per member per month (PMPM) costs for SFY '99 through '07 are exhibited on page 17. The VHAP annual enrollment data and per member per month (PMPM) costs for SFY '99 through '07 are exhibited on page 18.

Pharmacy Programs

The pharmacy benefits in Vermont's health care programs have undergone an upheaval due to the implementation of Medicare Part D as the primary prescription drug insurance for those with Medicare. Each program is described in more detail below. To summarize:

MEDICAID

People with both Medicaid and Medicare are known as full dual eligibles. Medicaid used to be the primary payer for prescription drugs, but this responsibility will now belong to Part D. The only Medicaid pharmacy benefit is for drug classes that are excluded from Part D coverage. Because coverage for these classes is in the new VPharm coverage, these costs are included in the VPharm portion of the budget.

VHAP-PHARMACY, VSCRIPT, VSCRIPT EXPANDED

These programs also used to be the primary payer for prescription drugs. For those people who have Medicare, this responsibility will now belong to Part D. VPharm provides secondary benefits as described below.

For individuals who are not on Medicare (for example those who do not have sufficient work quarters or are in a waiting period), a state pharmacy program will continue to be the primary payer.

VPharm

The *VPharm* program was established by Act 71 of the 2005 Vermont Legislature to provide secondary benefits for people who are eligible for Medicare and therefore eligible for Part D as their primary prescription insurance.

Medicaid/Medicare Beneficiaries: Medicaid continues to cover drugs in the classes that are excluded from Medicare Part D and generally not covered by the prescription drug plan. These include benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; and drugs when used for anorexia, weight loss, or weight gain. Medicaid/Medicare beneficiaries must pay their own co-payments for all the drugs covered by the Part D plan.

VPharm

Year	Caseload	Expenditures
SFY '06 Budget Adjustment	30,381	4,942,082
SFY '07 Gov. Rec.	30,381	11,779,321

Pharmacy Program Beneficiaries:

For those individuals not eligible for Medicare who have income at or below 150% FPL, VPharm covers the same classes listed above as well as any prescription drug plan premium and cost-sharing not paid by the federal low-income subsidy, resulting in the beneficiary paying only the VPharm premium for all drug coverage. Beneficiaries must pay a VPharm premium of $13 to the state to get this coverage.

For those individuals eligible for Medicare whose income is over 150% FPL, but no greater than 225%, VPharm covers maintenance drugs in the classes listed above as well as prescription drug plan premiums and cost-sharing for maintenance drugs in the Part D covered classes. Therefore, the beneficiary pays only the VPharm premium of $17 or $35 to the state for all maintenance drug coverage.

VHAP-Pharmacy

The *VHAP-Pharmacy* program, also part of the 1115 waiver to Title XIX of the Social Security Act, covers medications for low-income individuals (up to 150% of the FPL) who are at least age 65 or receive social security disability payments and are not eligible for Medicare. Beneficiaries pay a monthly premium of $13.00 and have no co-payments or deductibles.

VHAP-Pharmacy

Year	Caseload	Expenditures
SFY '04 Actual	8,424	16,221,334
SFY '05 Actual	8,446	19,157,825
SFY '06 Budget Adjustment	8,818	10,857,410

VScript

The *VScript* program covers only maintenance drugs for low-income individuals (up to 175% of the FPL) who are at least age 65 or receive social security disability payments and are not eligible for VHAP-Pharmacy or Medicare. Beneficiaries pay a monthly premium of $17.00 and have no co-payments or deductibles.

VScript

Year	Caseload	Expenditures
SFY '04 Actual	2,949	5,579,045
SFY '05 Actual	2,741	6,192,507
SFY '06 Budget Adjustment	2,847	3,205,599

VScript Expanded

The *VScript Expanded* program covers only maintenance drugs for low-income individuals (up to 225% of the FPL) who are at least age 65 or receive social security disability payments and are not eligible for VHAP-Pharmacy or Medicare. Beneficiaries pay a monthly premium of $35.00 and have no co-payments or deductibles.

VScript Expanded

Year	Caseload	Expenditures
SFY '04 Actual	2,860	2,891,798
SFY '05 Actual	2,615	5,985,715
SFY '06 Budget Adjustment	2,695	3,012,123

VHAP-Pharmacy, VScript, VScript Expanded

VHAP-Pharmacy, VScript, VScript Expanded

Year	Caseload	Expenditures
SFY '06 Budget Adjustment	400	471,941
SFY '07 Gov. Rec.	***400***	1,051,488

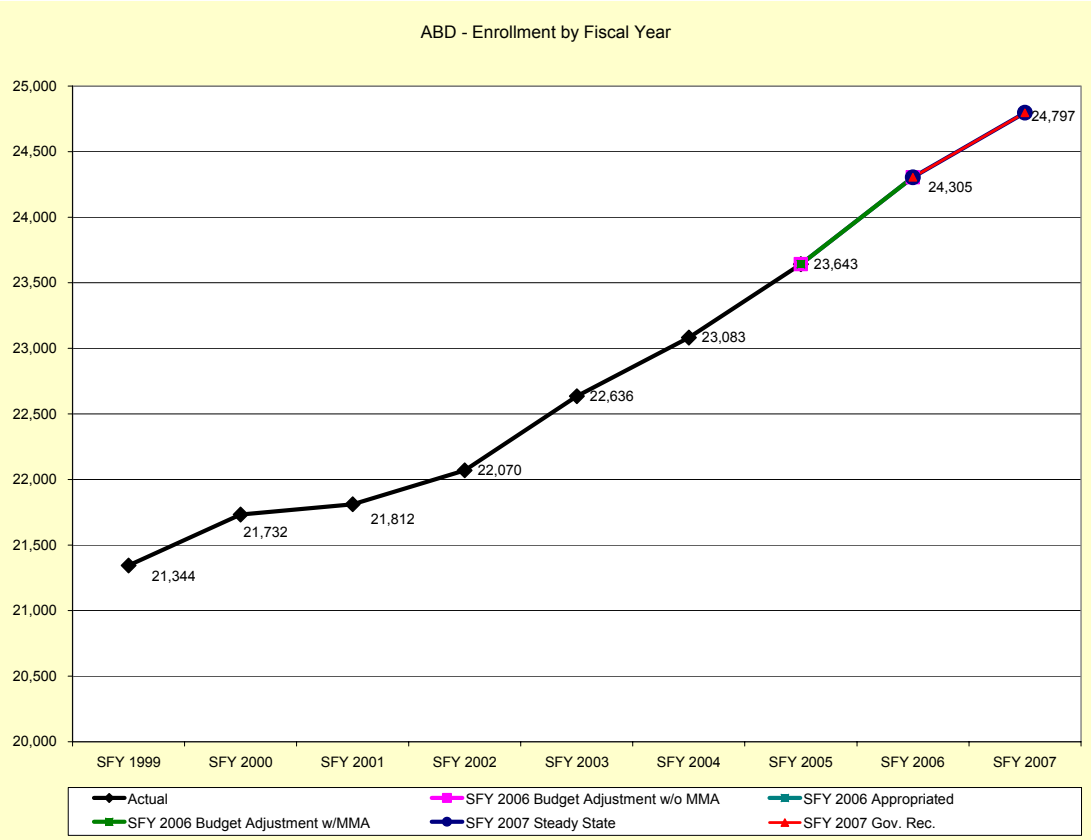
NOTE: The combined pharmacy programs' annual enrollment data and per member per month (PMPM) costs for SFY '99 through '07 are exhibited on page 19.

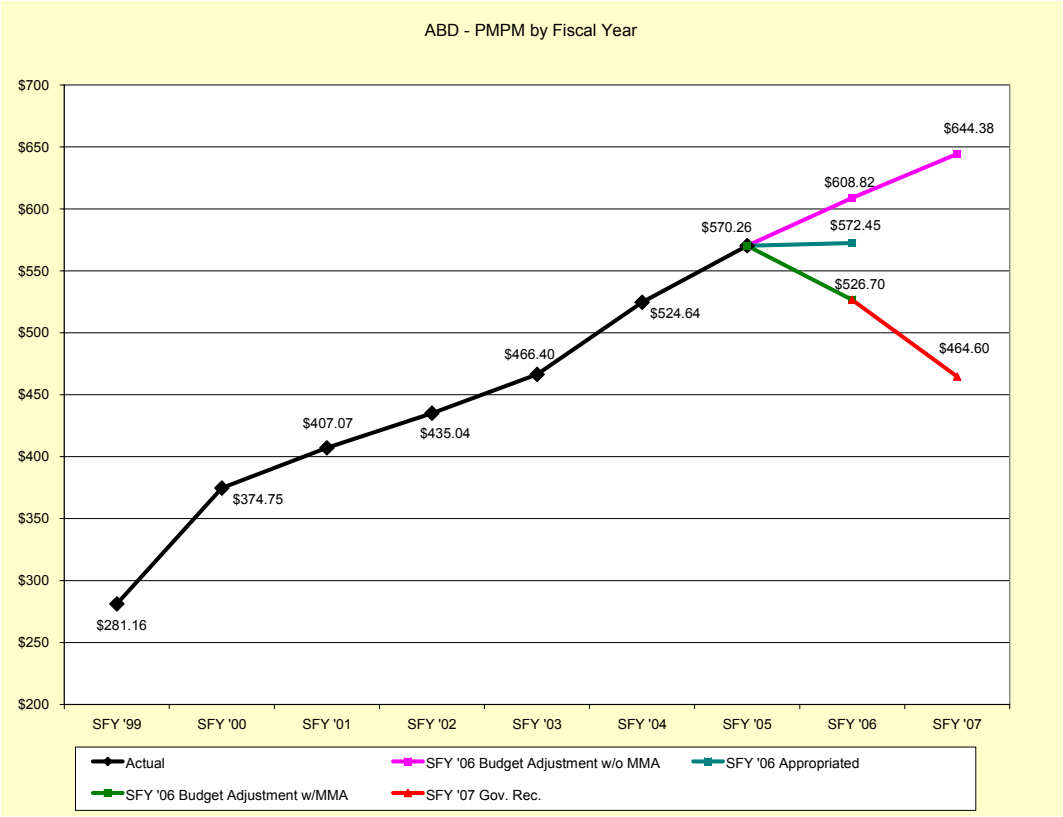
Healthy Vermonters

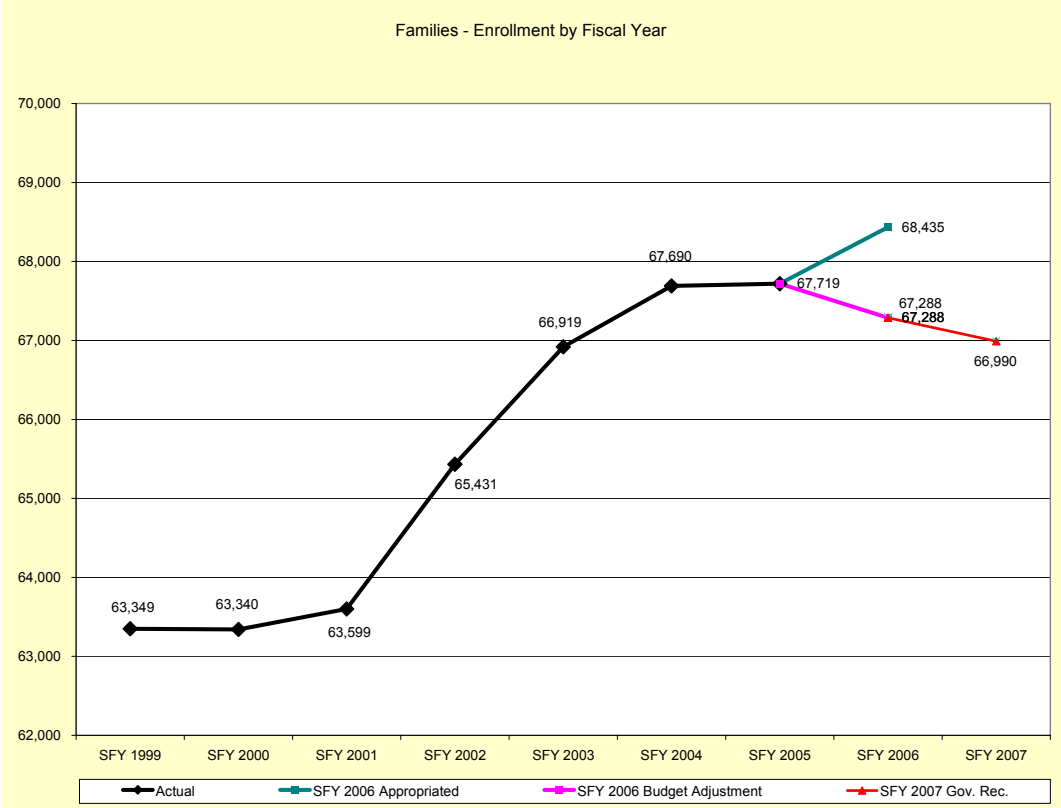
The *Healthy Vermonters* program allows beneficiaries to obtain their prescriptions at the Medicaid rate. Individuals who are at least age 65 (or those receiving social security disability benefits) up to 400% of the FPL and all others up to 300% of the FPL are eligible. Medicare beneficiaries may utilize this benefit only for drug classes that are excluded from Medicare Part D and not covered by their prescription drug plan.

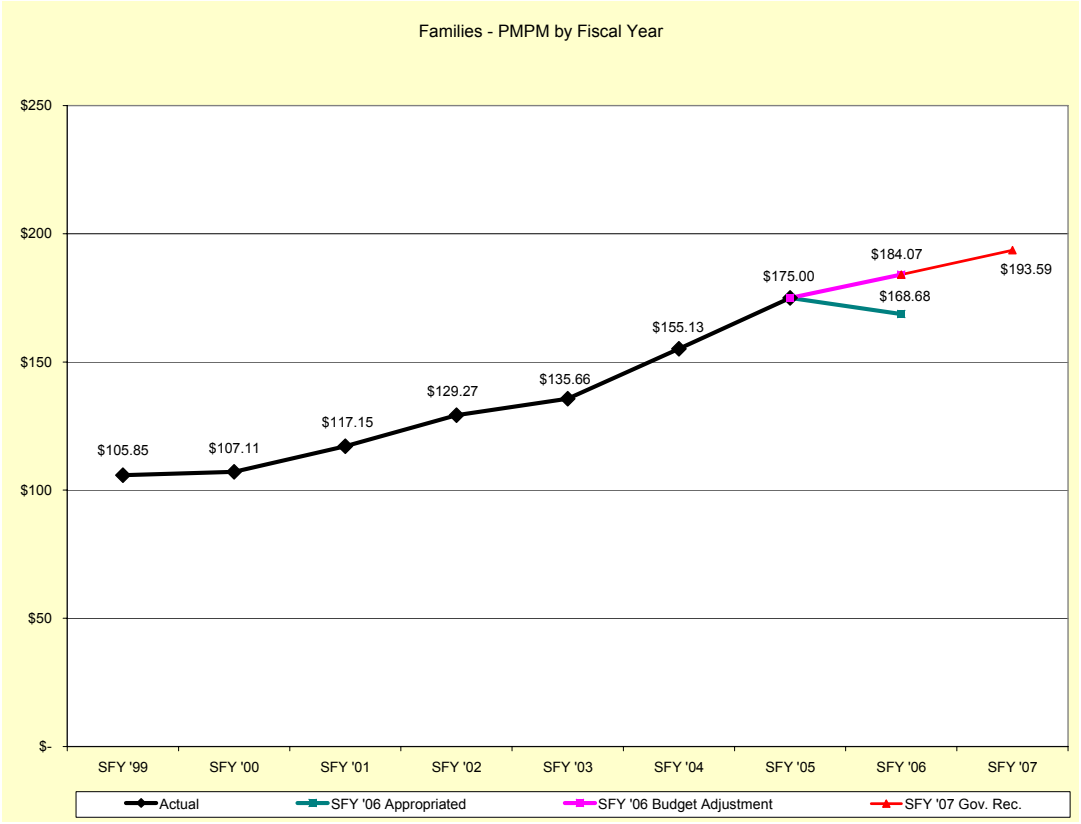
Healthy Vermonters

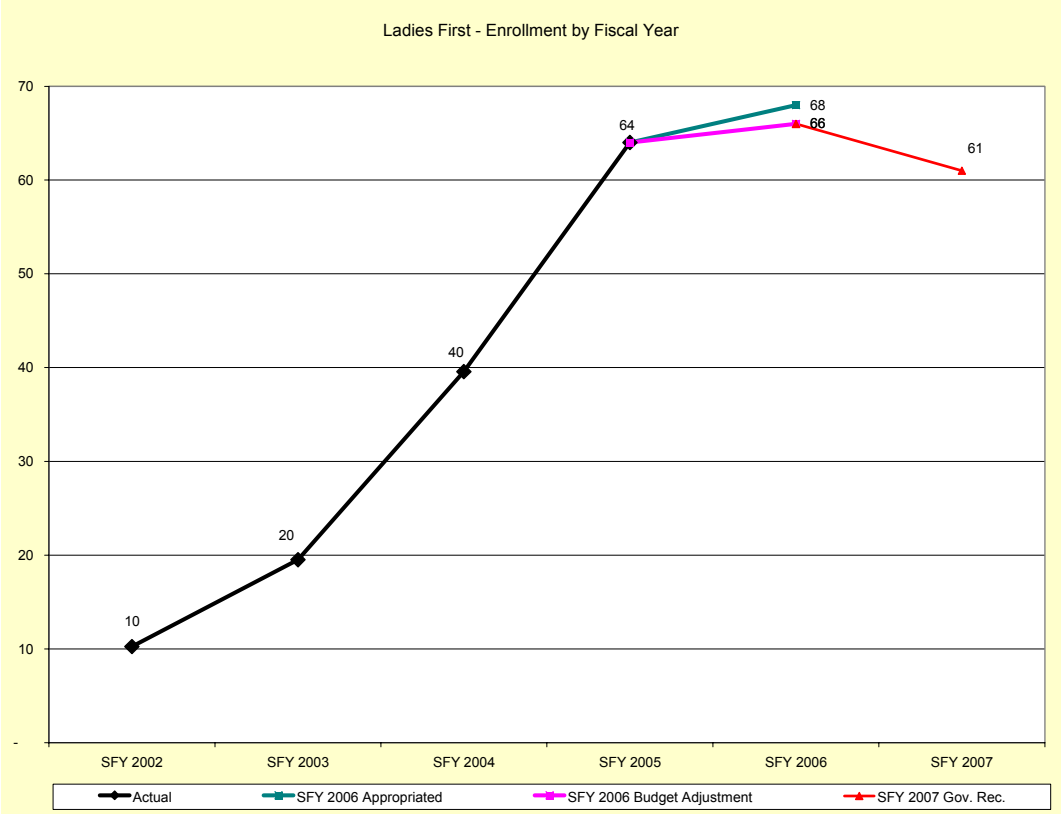
Year	Caseload	Expenditures
SFY '04 Actual	11,159	0
SFY '05 Actual	13,255	0
SFY '06 Budget Adjustment	11,355	0
SFY '07 Gov. Rec.	***13,733***	0

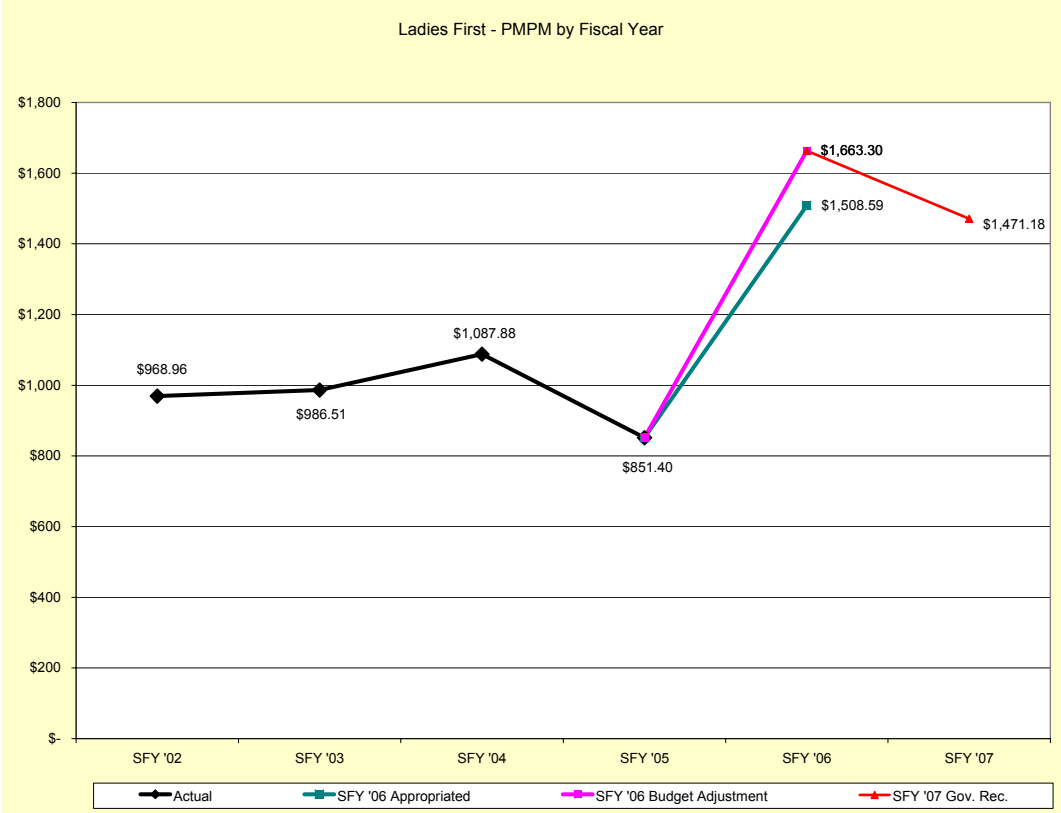

ABD - Enrollment by Fiscal Year
25,000
24,500
24,000
23,500
23,000
22,500
22,000
21,500
21,000
20,500
20,000
21,344
21,732
21,812
22,070
22,636
23,083
23,643
24,305
24,797
SFY 1999
SFY 2000
SFY 2001
SFY 2002
SFY 2003
SFY 2004
SFY 2005
SFY 2006
SFY 2007
Actual
SFY 2006 Budget Adjustment w/o MMA
SFY 2006 Appropriated
SFY 2006 Budget Adjustment w/MMA
SFY 2007 Steady State
SFY 2007 Gov. Rec.

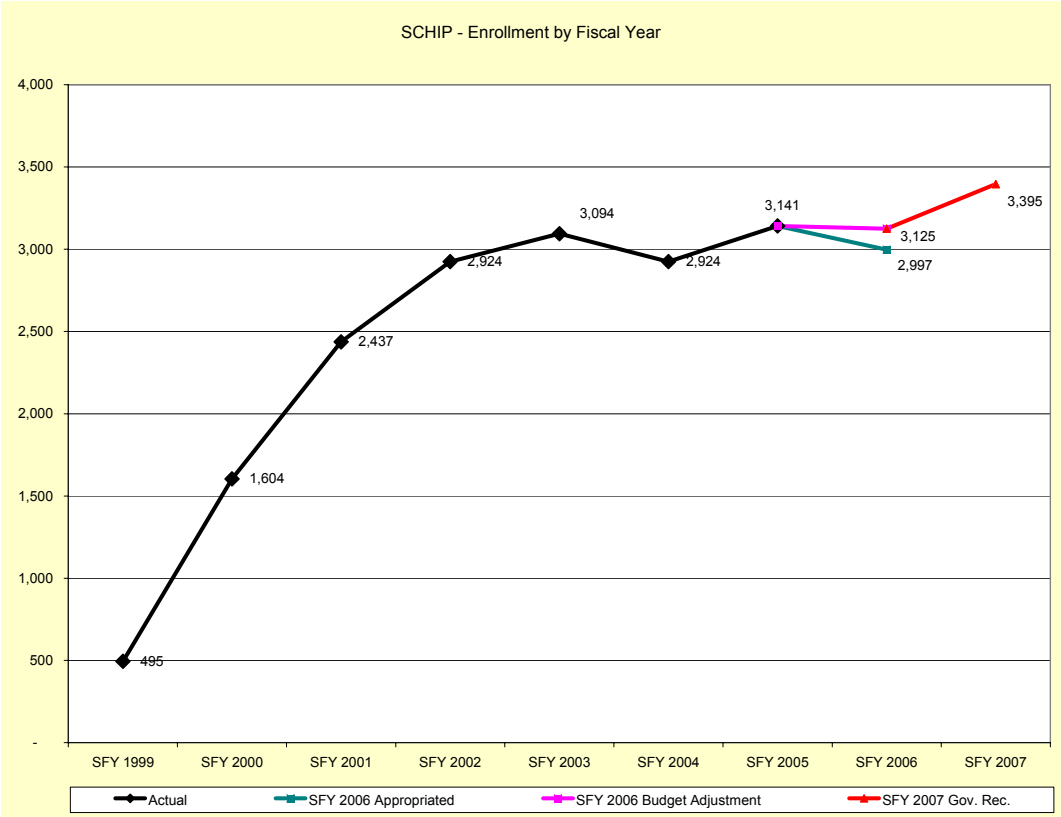

ABD - PMPM by Fiscal Year
$700
$650
$600
$550
$500
$450
$400
$350
$300
$250
$200
$281.16
$374.75
$407.07
$435.04
$466.40
$524.64
$570.26
$572.45
$526.70
$464.60
$608.82
$644.38
SFY '99
SFY '00
SFY '01
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07
Actual
SFY '06 Budget Adjustment w/o MMA
SFY '06 Appropriated
SFY '06 Budget Adjustment w/MMA
SFY '07 Gov. Rec.

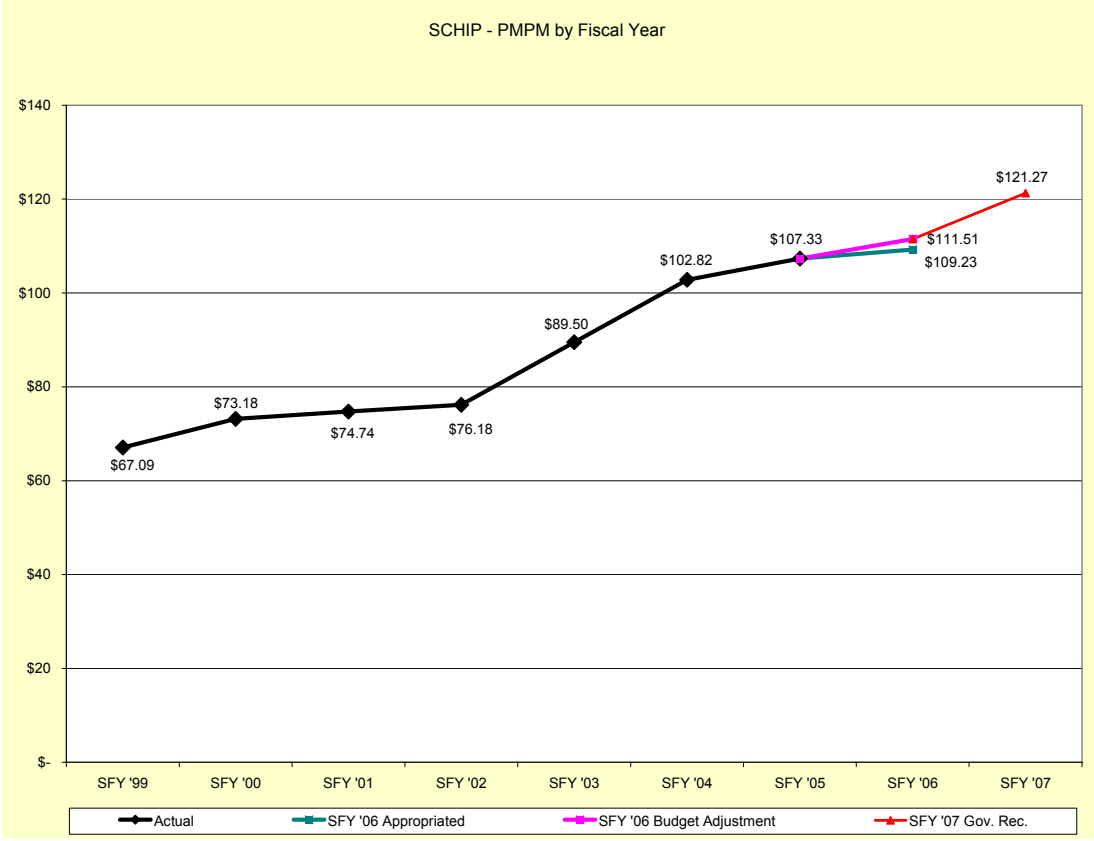

Families - Enrollment by Fiscal Year
70,000
69,000
68,000
67,000
66,000
65,000
64,000
63,000
62,000
63,349
63,340
63,599
65,431
66,919
67,690
67,719
68,435
67,288
67,288
66,990
SFY 1999
SFY 2000
SFY 2001
SFY 2002
SFY 2003
SFY 2004
SFY 2005
SFY 2006
SFY 2007
Actual
SFY 2006 Appropriated
SFY 2006 Budget Adjustment
SFY 2007 Gov. Rec.

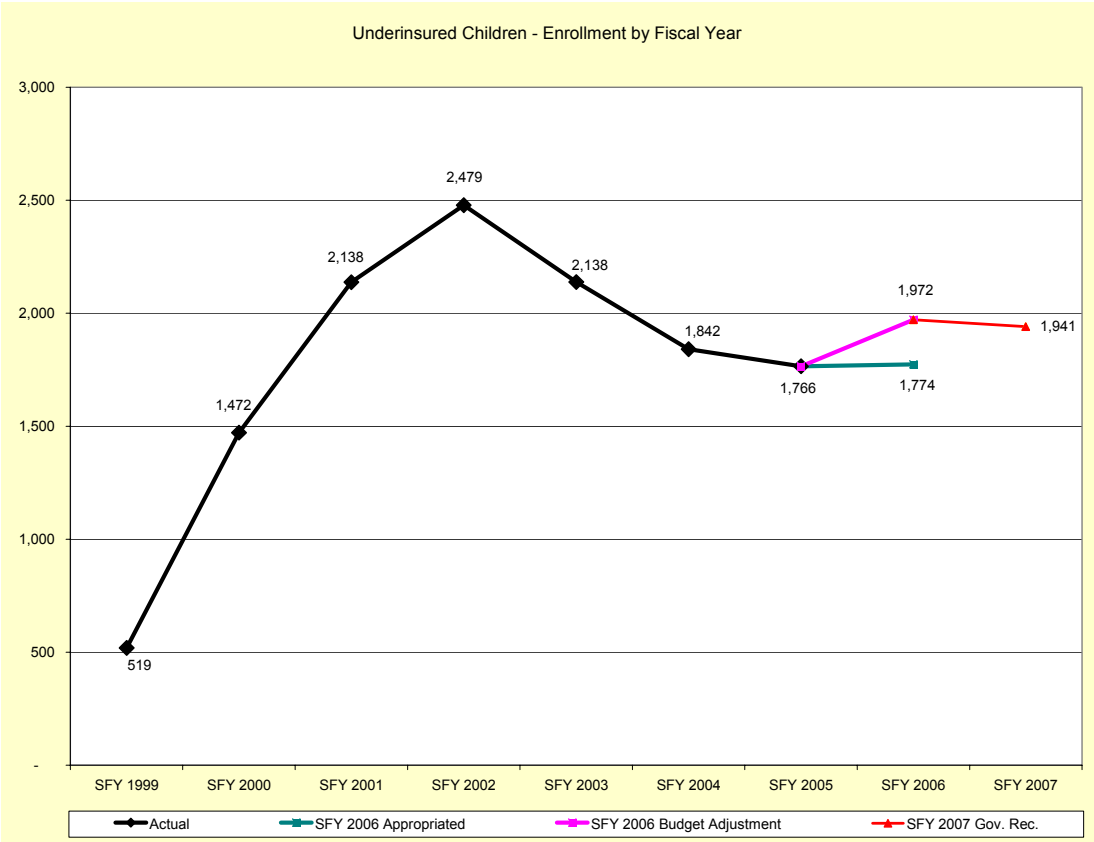

Families - PMPM by Fiscal Year
$250
$200
$150
$100
$50
$-
$105.85
$107.11
$117.15
$129.27
$135.66
$155.13
$175.00
$168.68
$184.07
$193.59
SFY '99
SFY '00
SFY '01
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07
Actual
SFY '06 Appropriated
SFY '06 Budget Adjustment
SFY '07 Gov. Rec.

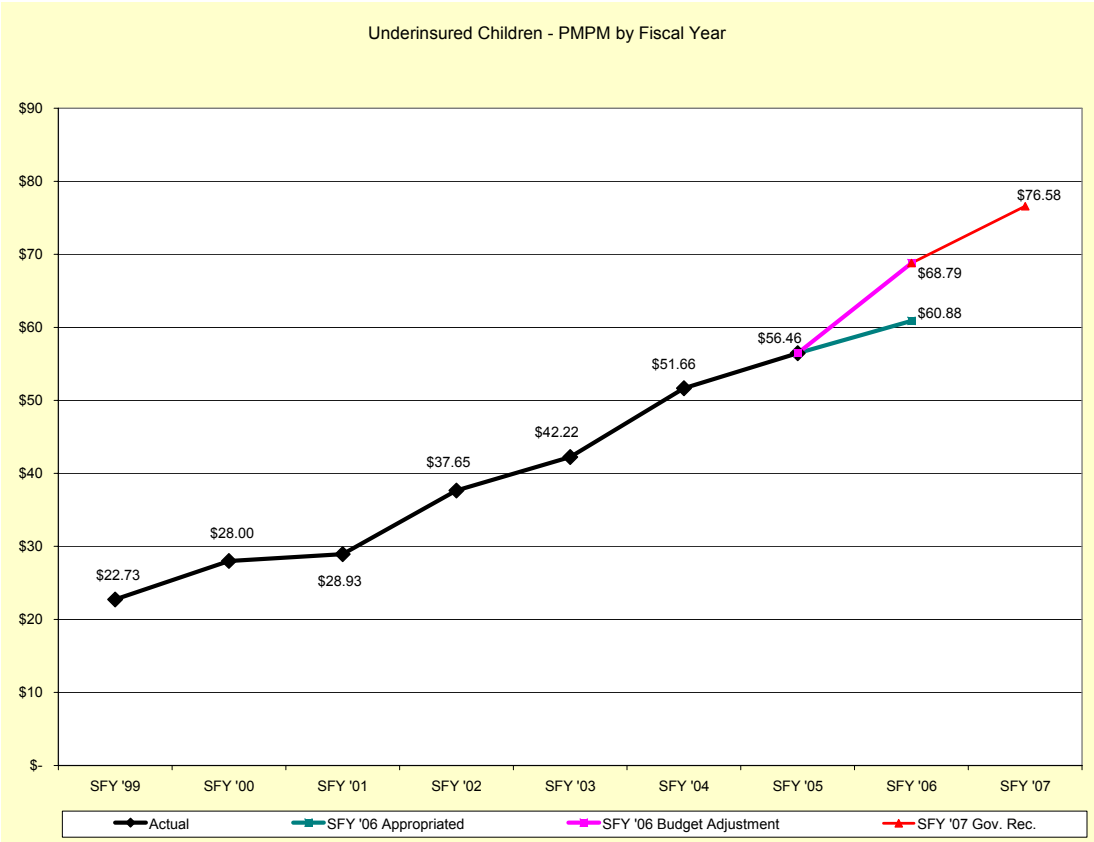

Ladies First - Enrollment by Fiscal Year
70
60
50
40
30
20
10
-
10
20
40
64
68
66
61
SFY 2002
SFY 2003
SFY 2004
SFY 2005
SFY 2006
SFY 2007
Actual
SFY 2006 Appropriated
SFY 2006 Budget Adjustment
SFY 2007 Gov. Rec.

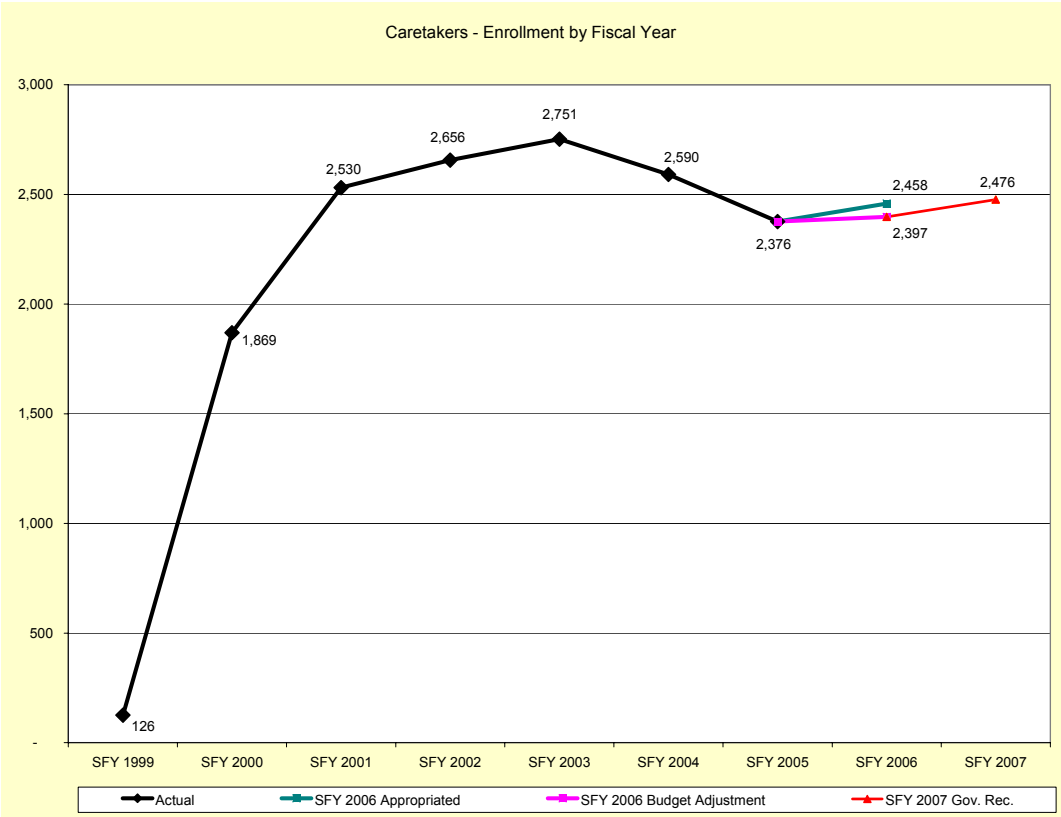

Ladies First - PMPM by Fiscal Year
$1,800
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$-
$968.96
$986.51
$1,087.88
$851.40
$1,508.59
$1,663.30
$1,471.18
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07
Actual
SFY '06 Appropriated
SFY '06 Budget Adjustment
SFY '07 Gov. Rec.

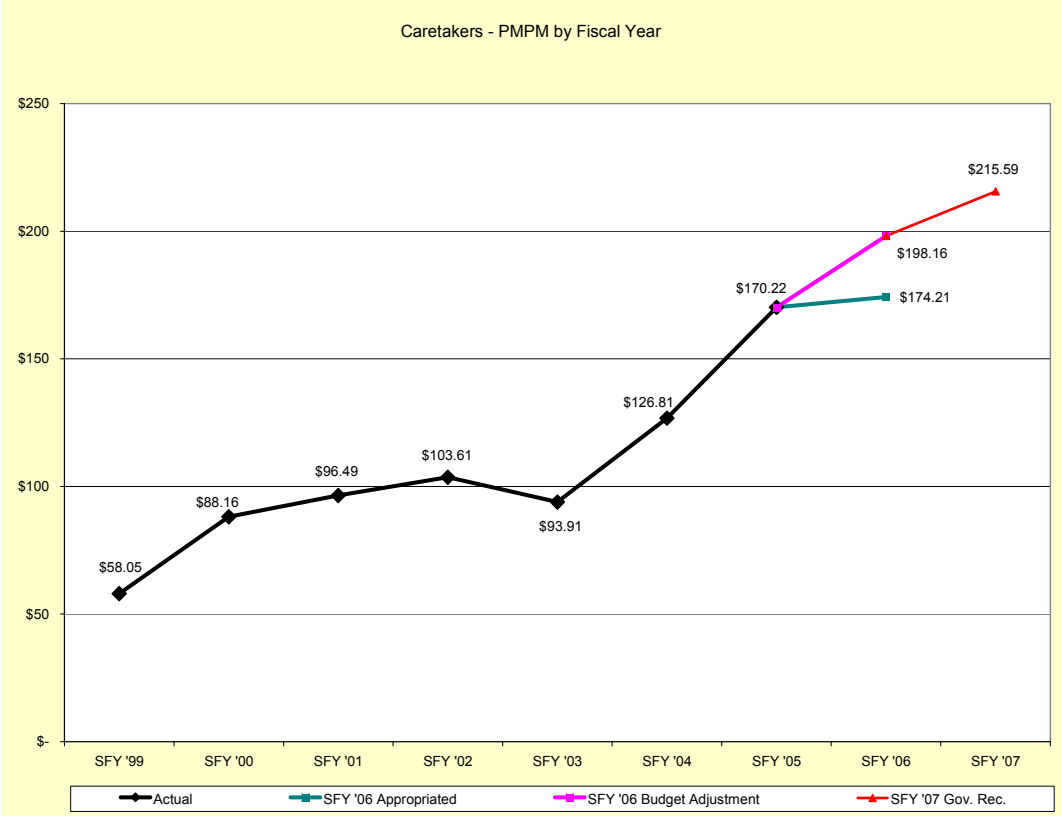

SCHIP - Enrollment by Fiscal Year
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
-
495
1,604
2,437
2,924
3,094
2,924
3,141
3,125
2,997
3,395
SFY 1999
SFY 2000
SFY 2001
SFY 2002
SFY 2003
SFY 2004
SFY 2005
SFY 2006
SFY 2007
Actual
SFY 2006 Appropriated
SFY 2006 Budget Adjustment
SFY 2007 Gov. Rec.

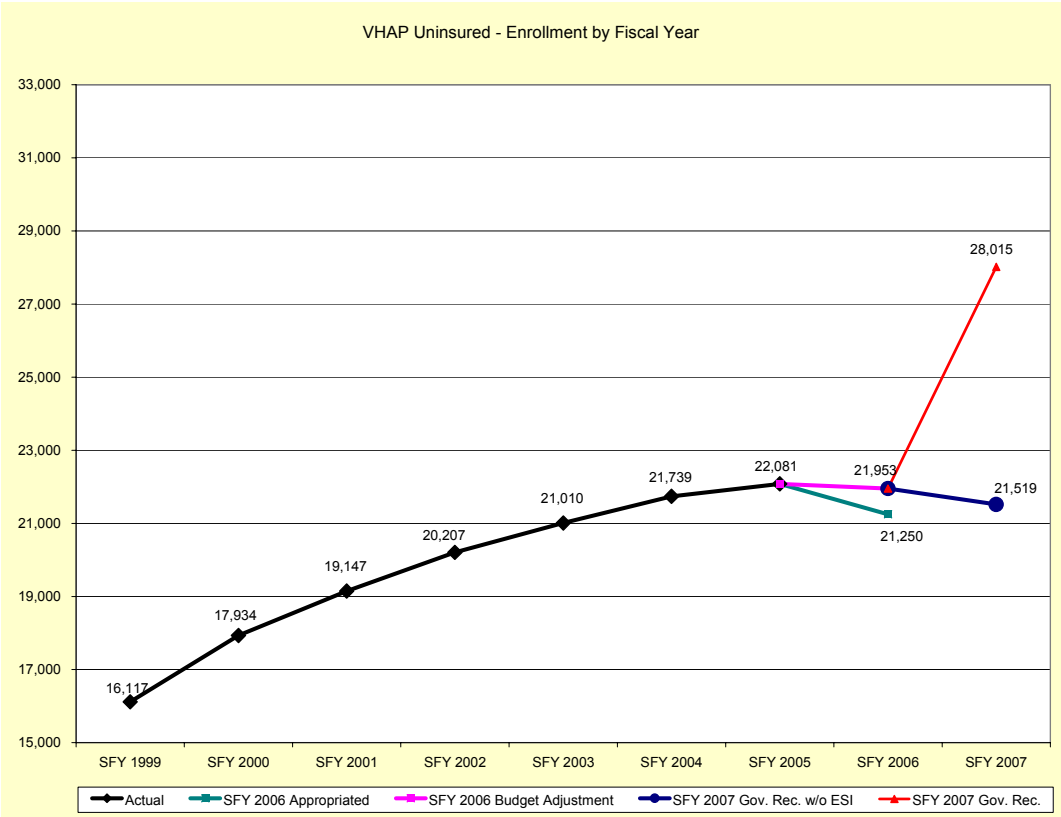

SCHIP - PMPM by Fiscal Year
$140
$120
$100
$80
$60
$40
$20
$-
$67.09
$73.18
$74.74
$76.18
$89.50
$102.82
$107.33
$109.23
$111.51
$121.27
SFY '99
SFY '00
SFY '01
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07
Actual
SFY '06 Appropriated
SFY '06 Budget Adjustment
SFY '07 Gov. Rec.

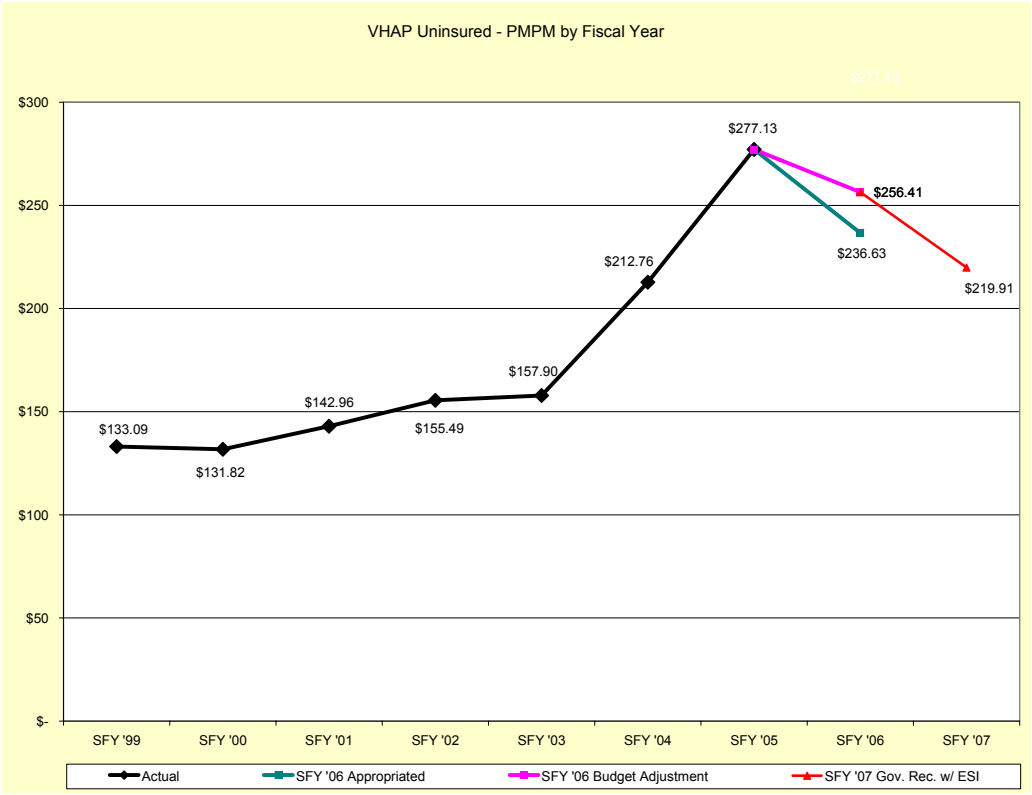

Underinsured Children - Enrollment by Fiscal Year
3,000
2,500
2,000
1,500
1,000
500
-
519
1,472
2,138
2,479
2,138
1,842
1,766
1,774
1,972
1,941
SFY 1999
SFY 2000
SFY 2001
SFY 2002
SFY 2003
SFY 2004
SFY 2005
SFY 2006
SFY 2007
Actual
SFY 2006 Appropriated
SFY 2006 Budget Adjustment
SFY 2007 Gov. Rec.

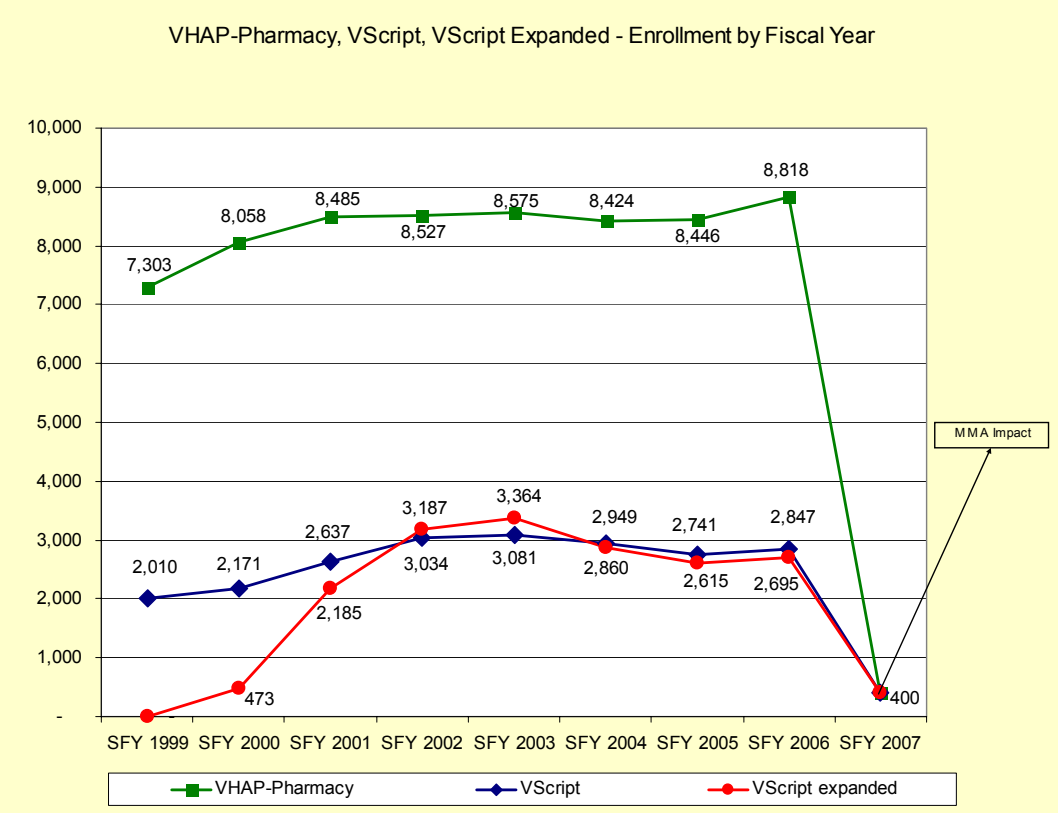

Underinsured Children - PMPM by Fiscal Year
$90
$80
$70
$60
$50
$40
$30
$20
$10
$-
$22.73
$28.00
$28.93
$37.65
$42.22
$51.66
$56.46
$60.88
$68.79
$76.58
SFY '99
SFY '00
SFY '01
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07
Actual
SFY '06 Appropriated
SFY '06 Budget Adjustment
SFY '07 Gov. Rec.

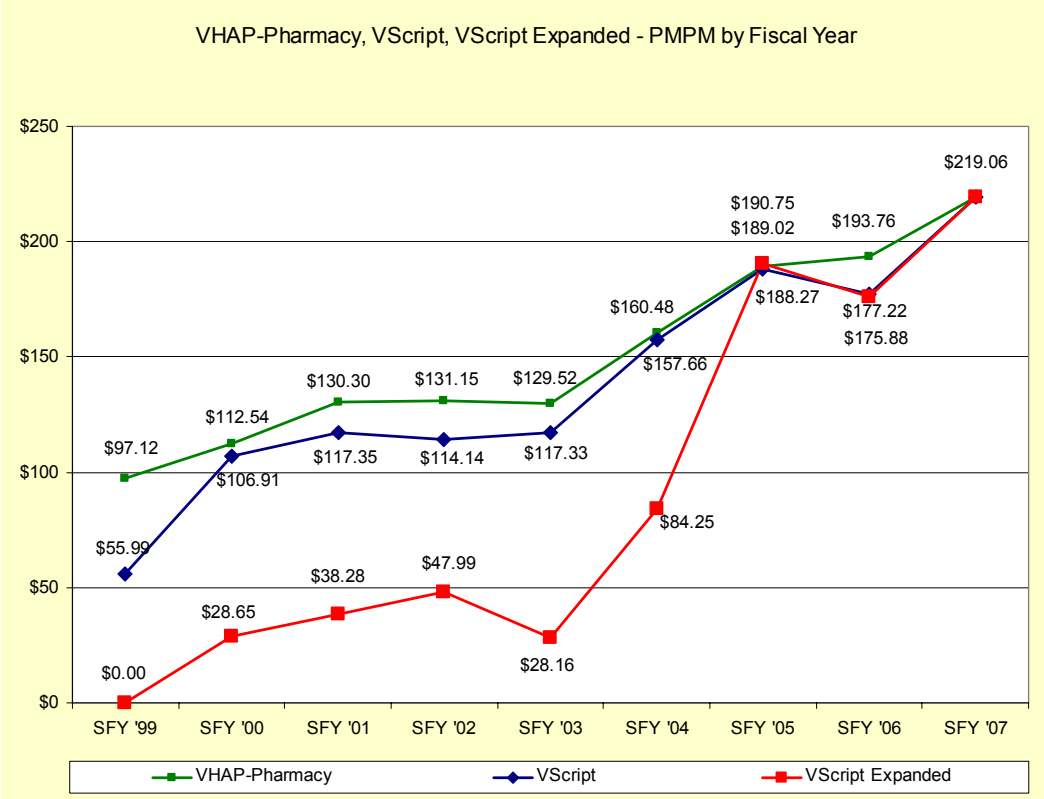

Caretakers - Enrollment by Fiscal Year
3,000
2,500
2,000
1,500
1,000
500
-
126
1,869
2,530
2,656
2,751
2,590
2,376
2,458
2,397
2,476
SFY 1999
SFY 2000
SFY 2001
SFY 2002
SFY 2003
SFY 2004
SFY 2005
SFY 2006
SFY 2007
Actual
SFY 2006 Appropriated
SFY 2006 Budget Adjustment
SFY 2007 Gov. Rec.


Caretakers - PMPM by Fiscal Year
$250
$200
$150
$100
$50
$-
$58.05
$88.16
$96.49
$103.61
$93.91
$126.81
$170.22
$174.21
$198.16
$215.59
SFY '99
SFY '00
SFY '01
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07
Actual
SFY '06 Appropriated
SFY '06 Budget Adjustment
SFY '07 Gov. Rec.


VHAP Uninsured - Enrollment by Fiscal Year
33,000
31,000
29,000
27,000
25,000
23,000
21,000
19,000
17,000
15,000
16,117
17,934
19,147
20,207
21,010
21,739
22,081
21,953
21,519
21,250
28,015
SFY 1999
SFY 2000
SFY 2001
SFY 2002
SFY 2003
SFY 2004
SFY 2005
SFY 2006
SFY 2007
Actual
SFY 2006 Appropriated
SFY 2006 Budget Adjustment
SFY 2007 Gov. Rec. w/o ESI
SFY 2007 Gov. Rec.


VHAP Uninsured - PMPM by Fiscal Year
$300
$250
$200
$150
$100
$50
$-
$133.09
$131.82
$142.96
$155.49
$157.90
$212.76
$277.13
$256.41
$236.63
$219.91
SFY '99
SFY '00
SFY '01
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07
Actual
SFY '06 Appropriated
SFY '06 Budget Adjustment
SFY '07 Gov. Rec. w/ ESI


VHAP-Pharmacy, VScript, VScript Expanded - Enrollment by Fiscal Year
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
7,303
8,058
8,485
8,527
8,575
8,424
8,446
8,818
2,010
2,171
2,637
3,034
3,081
2,860
2,615
2,695
2,847
473
2,185
3,187
3,364
2,949
2,741
400
MMA Impact
SFY 1999
SFY 2000
SFY 2001
SFY 2002
SFY 2003
SFY 2004
SFY 2005
SFY 2006
SFY 2007
VHAP-Pharmacy
VScript
VScript expanded


VHAP-Pharmacy, VScript, VScript Expanded - PMPM by Fiscal Year
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$200
$150
$100
$50
$0
$97.12
$112.54
$130.30
$131.15
$129.52
$160.48
$190.75
$189.02
$193.76
$219.06
$55.99
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$114.14
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$157.66
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$177.22
$175.88
$0.00
$28.65
$38.28
$47.99
$28.16
$84.25
SFY '99
SFY '00
SFY '01
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07
VHAP-Pharmacy
VScript
VScript Expanded

Section 4: Global Commitment to Health with Implementation Steps

What is an 1115 Demonstration waiver?

The federal government has the ability to "waive" many, but not all, of the laws governing Medicaid. They can "waive" some of the required services covered by Medicaid and who can be determined eligible for Medicaid coverage. The federal government developed the 1115 Demonstration waiver program to encourage state innovation in the Medicaid program. Often, states identify ways to save Medicaid funds and to use the savings to expand coverage.

Using the 1115 Demonstration waiver program, Vermont has been a national leader in providing affordable health coverage available to low-income children (Dr. Dynasaur), adults (Vermont Health Access Plan - VHAP) and people with disabilities. As a result, some form of Medicaid covers nearly one in four Vermonters. Vermont has one of the lowest rates of uninsured people in the nation. The new long-term care waiver (Choices for Care) is also an 1115 waiver program.

Why does Vermont need the Global Commitment?

Vermont's achievements are in jeopardy from the escalating cost of health care, changes in the rates of federal participation in this program, and dependence on state revenue sources that do not grow at the rate of medical inflation. Vermont's Medicaid program faces the prospect of a cumulative deficit (over the upcoming five fiscal years) of approximately $370 million in state funds.

To help address the deficit, as of October 1, 2005, Vermont entered into a new five-year comprehensive 1115 Demonstration waiver called the ***Global Commitment to Health.*** The goals of the Global Commitment to Health waiver are to:

- provide Vermont with financial and programmatic flexibility to help maintain its broad public health care coverage and provide more effective services;
- continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and
- foster innovation in health care by focusing on health care outcomes.

What is Global Commitment?

Under the Global Commitment to Health waiver, overall expenditures (state and federal dollars) for Vermont Medicaid services over the next five years are capped at $4.7 billion. 1115 waivers always have a "budget neutrality" cap that means the federal government is held harmless for any spending above what "would have occurred" in the absence of the waiver.

The waiver program converts the Office of Vermont Health Access (OVHA), Vermont's Medicaid organization, to a public managed care organization (MCO). Prior to Global Commitment about two-thirds of Medicaid-funded services were provided by physicians, dentists and other private practitioners (hospitals, etc.). The other one-third of the Medicaid-funded services were provided through services managed by other departments, including the Department of Health; Department of Disabilities, Aging and Independent Living (DAIL); the Department for Children and Families (DCF); and by local schools. Under Global Commitment, the Agency of Human Services (AHS) will pay the Office of Vermont Health Access a lump sum premium payment to ensure the provision of all Medicaid services in Vermont (with the exception of the new long-term care waiver, which is managed separately). This premium payment is based on historical Vermont Medicaid spending and an actuary must certify that it is sufficient to cover all services.

The AHS has an Intergovernmental Agreement (IGA) with the OVHA that includes requirements set by the federal government for managed care organizations (MCOs). The OVHA will have IGAs with AHS departments and the Department of Education based on existing programs, expertise, and budget allocations. Departments will continue to develop their own policies and practices for their particular populations and services, and receive appropriations through the existing budget and legislative process. A few changes will need to be made (i.e., Grievance and Appeals process), but overall, policy and practices will not change within the departments due to the new waiver organizational structure.

What are the advantages of this new waiver?

In September of 2005, the Vermont legislature approved entering into the waiver agreement because of the potential financial and programmatic benefits for Vermont.[1]

The Global Commitment waiver provides Vermont with federal authority to continue the VHAP-Uninsured, VHAP-Pharmacy, VScript, PC Plus and CRT programs developed under the previous 1115 Demonstration waiver. The 1915 home and community-based waivers that support services for people with developmental disabilities, people with traumatic brain injuries, children with severe emotional disturbances, and people with disabilities who need personal care services and supports are also included in the Global Commitment waiver.

A primary fiscal advantage to the MCO model is that the MCO can invest in health services irrespective of their current funding source, as long as they are responsible investments that provide necessary health care services for Vermonters. This will enable Vermont to bring in an estimated $135 to $165 million in new federal funds. The ability to invest in programs that are currently operating at the state or local level, allows

[1] The Legislative Joint Fiscal Committee unanimously granted approval for the Global Commitment to Health Demonstration Waiver Program to begin on October 1, 2005, contingent on the following being provided by November 17, 2005: 1) a more thorough explanation of waiver provisions; 2) final information about premium rates and methodologies; 3) a list of criteria and MCO targeted health care investments; and 4) review by the Attorney General.

Vermont to reduce the projected five-year general fund (GF) deficit by this amount, and helps to address a large portion of the projected deficit for the coming fiscal year (FY07). This opportunity (to invest in tangible health care programs that heretofore have not been federal-state partnerships) is potentially an enormous opportunity for the state.

The waiver provides Vermont with the ability to be more flexible in how it uses its Medicaid resources because Vermont is not constricted by traditional Medicaid rules. Examples of this flexibility include utilization of creative payment mechanisms (e.g., case rates, capitation, combining funding streams for different populations) rather than fee-for-service to pay for services not traditionally reimbursable through Medicaid (e.g., consultation for pediatricians by psychiatrists regarding mental health issues) and investment in innovative programmatic initiatives (e.g., the Chronic Care Initiative and prevention programs).

The waiver encourages inter-departmental collaboration and consistency across programs. It is projected that this type of flexibility will enable Vermont to implement programs and reimbursement mechanisms in the first few years of the program that will curb the health care inflation experienced within Vermont and thereby reduce even more of the projected five-year deficit. Additional savings may be realized to the extent Vermont is able to more effectively address beneficiaries' needs and encourage appropriate utilization.

While the waiver reduces the Medicaid deficit and provides additional tools for managing program expenditures, programmatic changes and/or new revenue sources will still be necessary to eliminate the deficit.

How will this affect Medicaid beneficiaries?

Current Medicaid beneficiaries will not experience any changes to their benefits or eligibility for services upon implementation of Global Commitment. As has been the case in the past, any changes to program eligibility or benefits requires approval of the Vermont legislature, and most would require federal review before implementation. The federal approval of the waiver is very explicit in that all mandatory populations and all mandatory benefits remain unchanged under the new waiver. However, some individuals previously not participating in PC Plus will be required to select a 'medical home' or primary care provider due to federal MCO requirements.

Medicaid beneficiaries who were not enrolled in VHAP, the existing 1115 Demonstration waiver program, were notified that they are now part of a new waiver demonstration program. They received notification that there were no changes to their benefits or services because of the new waiver program.

Is the cap too low?

Projections are that Vermont will only spend $4.18 billion dollars over the next five years for current beneficiaries and programs so there is room in the waiver cap ($4.7 billion) to

handle higher costs or an increase in beneficiaries. Currently Vermont does not have the General Fund dollars needed to support the full $4.18 billion for existing Medicaid services, so reaching the $4.7 billion cap would be challenging.

Monthly Capitation Payment (Premium)

As part of the Waiver, the OVHA will receive an actuarially-certified monthly capitation payment (i.e., premium) from the AHS to pay for health care services. The premium is established at $65,371,811 for the first year of the Waiver.

The following types of programs and/or services are included in the premium:

- All Acute Care Services (except acute care for LTC "Highest Needs" and "High Needs" groups and SCHIP enrollees)
- Mental health services, including CRT
- Developmental Services
- Substance Abuse Treatment
- VPharm: Medicare Non-Covered (OTCs & Excluded Classes)
- VHAP-Rx and VScript: Non-Duals
- Medicaid-Funded Programs Administered by DOH, DCF, DOE and DOC

The following types of MCO administrative expenses are included in the premium:

- Program Management
- Claims Processing
- Member Services
- Clinical Management
- Provider Services
- Program Development
- Coordination of Benefits/TPL

MCO administrative expenses are included in the actuarially-certified capitation amount, but are not included in the monthly premium payment; all administrative expenses are claimed in accordance with Title XIX laws and regulations. If MCO revenues exceed MCO expenses, the MCO may fund programs or activities permitted under the Waiver's Terms and Conditions.

The following types of administrative expenses are excluded from the Actuarially-Certified Capitation Amount:

- AHS Central Office
- LTC (program administration, third-party liability)
- Eligibility Determination
- SCHIP Administration
- System Enhancements
- Monthly Enrollee Premiums

Other Waiver Considerations

The following types of programs, services and administrative expenses are excluded from the Global Commitment to Health waiver but included in Vermont's long-term care 1115 waiver:

- Highest and High Needs groups: all Medicaid-eligible services, moderate needs (expansion) group: long-term care services only
- Individuals eligible for both CRT and Choices for Care: all Medicaid services except CRT services (CRT, inpatient and ambulatory behavioral health)

The following programs, services and administrative expenses are excluded from both the Global Commitment to Health and long-term care waivers:

- Disproportionate Share Hospital (DSH) payments
- State Children's Health Insurance Program (SCHIP) - medical and administrative expenses
- VPharm - wraparound expenses
- Part D "Clawback" payments
- Administrative expenditures for systems enhancements

Managed Care Organization (MCO) Requirements

The OVHA is responsible for fortifying certain existing processes and implementing new requirements pertinent to the federal MCO regulations. The following table depicts the primary requirement category with the subcategory and timeline for completion:

Primary Requirement Category	Subcategory	Timeline For Completion
Member Services	▪ Interpreter Services ▪ Provider Directory ▪ Notification of Terminating Providers ▪ Enrollee Handbook ▪ Advance Directives ▪ Member Helpline	To be completed over the course of 2006.
Grievances & Appeals	▪ Notice of Adverse Action ▪ Acknowledgement of Appeal ▪ Resolution ▪ Fair Hearings	Majority of planning tasks completed by February 1, 2006 Rules to be completed over the course of 2006.
Quality Assessment & Performance Improvement (QAPI)	▪ QAPI Plan ▪ Source of Primary Care for each enrollee ▪ Practice Guidelines ▪ Measuring Performance Improvement	March 1, 2006

Primary Requirement Category	Subcategory	Timeline For Completion
Program Integrity	▪ Actuarial Certification of Capitation Rates ▪ Compliance Plan	Majority of tasks completed by January 1, 2006
Enrollee Access & Provider Network	▪ Availability of Services ▪ General Financial ▪ Budget Neutrality Reporting	February 1, 2006

Intergovernmental Agreements (IGA)

The OVHA and the AHS signed an Intergovernmental Agreement (IGA) to specify the responsibilities of the OVHA and the AHS specific to the Global Commitment waiver. An IGA template is in the process of finalization. This template is the basis for an Intergovernmental Agreement between the OVHA and specific departments: the Vermont Department of Health; the Department of Disabilities, Aging and Independent Living; the Department for Children and Families; and the Department of Education. A Memorandum of Understanding (MOU) is in development between the OVHA and the Department of Corrections.

Section 5: Care Coordination

Care Coordination is one piece of a comprehensive approach to system redesign and is not intended to "stand alone". In order to fully understand the initiative it must be placed in context. A separate Care Coordination presentation is necessary to accomplish this task. The power point presentation is included in Appendix 11.

The Goal of Care Coordination

In furtherance of the program flexibility granted by the Global Commitment, as stated in the 2006 Fiscal Year Budget, OVHA is committed to partnering with primary care providers, hospitals, AHS departments and community agencies in Vermont to address the need for enhanced coordination of services in a climate of increasingly complex health care needs and scarce resources. The Care Coordination Initiative will facilitate the patient-provider relationship by offering services that assist primary care practices in tending to the intricate medical and social needs of Medicaid beneficiaries without increasing the administrative burden. Ultimately the program will decrease inappropriate utilization of services.

Method

The foundation for care coordination is backed in the desire for Vermonters to help other Vermonters. As supported by the Chronic Care Model, care coordination emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room (ER) utilization.

Program Implementation

Beneficiaries who will most benefit from care coordination are selected based upon criteria identified through claims data ***and*** in collaboration with their individual primary care provider. The regionally based care coordination team consisting of one Registered Nurse (RN) and one social worker will devise a care plan through assessment of current treatments, services, and resources that directly address beneficiaries' needs. The team will ensure beneficiary compliance with the care plan and will monitor appropriate ER use, hospitalizations, length of stay and discharge planning.

As of January 2006, the pilot phase has commenced and one care coordination team is working in Caledonia County. Beneficiaries have been identified and the care coordinators are collaborating with primary care providers to commence the care plan process.

Personnel

January '06 – March '06 - Five staff members are needed for the first phase of the program. We have hired a Field Director for OVHA in addition to one nurse and one

social worker to be the team working in Caledonia County. We still have to hire one nurse and one social worker to work in Washington County.

April '06 – December '06 - Eleven more staff are to be hired during this phase: an Associate Medical Director; five nurses; and five social workers. A nurse and a social worker will work at Fanny Allen Health Care in Burlington. For the St. Albans/Morrisville region, there will be a nurse and a social worker. For the Rutland/Middlebury region, we will have a nurse and a social worker. There will be a nurse and a social worker to cover the Springfield and Brattleboro areas and another nurse and social worker team to cover the Bennington region.

Current Participating Practices, Agencies and Stakeholders

As of January 2006, the current participating practices, agencies and stakeholders include:

- Central Vermont Community Partnership
- Central Vermont Hospital (CVH)
- Central Vermont Physician Practice Corp. (CVPPC)
- Central Vermont Substance Abuse Services
- Community Health Center of Burlington
- Corner Medical
- Department for Children and Families - field service districts
- Department of Disabilities, Aging and Independent Living (DAIL)
- Fletcher Allen Medical Center
- Northeast Kingdom Human Services (NEKHS)
- Northeastern Vermont AHEC
- Northeastern Vermont Regional Hospital (NVRH)
- Northern Counties Health Care (NCHC)
- The Health Center of Plainfield
- Vermont Association of Hospitals & Health Systems (VAHHS)
- Vermont Department of Health offices in St. Johnsbury, Barre, and Burlington
- Washington County Mental Health
- Winooski Family Health

The AHS reorganization recognized the need for coordination of services at the community level. District office co-location of care coordination resources associated with a broad range of programs will allow those resources to be deployed most effectively. The program with the strongest role to play in an individual case will be able to take the lead with the support of other specialized resources. The care coordination teams contribute a critical component to the web of support the Agency of Human Services provides and establishes a unique relationship with the primary care provider, by providing the medical focus not addressed by any other program. Care coordinators will be informed about other statewide quality improvement initiatives, and will be able to assist providers to access their benefits. For example, they may be able to suggest a beneficiary's appropriateness for the Choices for Care Program sponsored by DAIL if the clinical condition seems to be approaching need for a nursing home level of care.

Because of OVHA's active participation in the Colorectal Cancer Screening Project, care coordinators will be able to assure providers that their complex patients are not missing out on the need for basic, age-appropriate screening. There are also opportunities for collaboration with Department of Corrections and VDH-ADAP through the Incarcerated Women's Initiative and the Capitated Program for Opiate Dependency. The result is the opportunity to collaborate creatively to address the unique needs of Vermonters in the context of an individual's care.

The Care Coordination Initiative will make a significant contribution to achieving the goals of the Vermont Blueprint for Health by addressing the unique characteristics of the Medicaid population and the challenges those with chronic conditions face in participating fully within the Chronic Care Model. Many individuals will need additional support to become the "informed, active patient" the model describes. The care coordination teams (a registered nurse and a social worker) will provide this by facilitating the implementation of the essential components of disease management programs as identified by Dr. Kenneth Thorpe. These include team-based care, cross-consortium coordination, patient education, outreach and care management. Because the care coordination teams are local individuals, they will be able to implement these components within the context of the beneficiary's community, considering what is available and acceptable to the beneficiary and their primary care provider.

Request for Proposal (RFP): Co-Management/Disease Management Project

Chronic illnesses and disabilities are often an overwhelming burden to low-income Vermonters and their families. These beneficiaries' needs run the spectrum from help with understanding and implementing specific disease interventions (i.e. health coach) to simply learning "best practices", for the patient to follow. In each individual case the key to better health through effective management of these conditions will be a combination of both a strong partnership between providers and patients as well as a common disease management strategy. The Institute for Health Care Improvement (IHI) describes "best practice" in this area as "care that builds patient and family skills and confidence, increases patient and family knowledge about the condition, increases provider's knowledge of the needs and preferences of the patient, and supports the patient and family in the psychosocial, as well as medical, responses to the condition". The key components of such care include: collaborative goal setting and shared decision making, regular follow-up, monitoring and assessment of progress towards goals, relating plans to patient's social and cultural environment, tracking and ensuring implementation, including linking support programs to the individual's regular source of medical care and monitoring their effects on a patient's health.

The Office of Vermont Health Access intends to support the development of systems of care that enable patients and clinicians to effectively co-manage chronic conditions and implement specific disease management strategies. Such systems of care will accomplish the following: utilize approaches currently identified as "best practice"; offer a combination of face to face (individual or group) and telephonic support; demonstrate effective strategies for engaging with low-income persons, individuals with disabilities and other special needs populations; include families and consumers as partners; and

maintain "aftercare" supports for people who have participated in group interventions or classes.

Eligible Population - Medicaid beneficiaries enrolled in the Primary Care Plus (PC Plus) primary care case management program will be eligible for participation in this initiative. These individuals have an identified primary care provider to serve as a "medical home", and OVHA has a complete set of professional, institutional and pharmacy claims that may be used to identify prospective patients and track their service utilization.

Implementation Strategy - Implementation of this RFP needs to be considered within the context of OVHA's overall vision of addressing the needs of a range of Medicaid beneficiaries with chronic medical conditions from the most complex to the more moderate. The most complex patients are the focus of OVHA's previously described Care Coordination Initiative. This RFP is designed to address the needs of those beneficiaries with more moderate needs - on a continuum extending downward from the Care Coordination population. It is OVHA's intent to gradually implement this RFP in a manner consistent with the medical priorities of its beneficiaries; sequencing its roll-out across the State in districts where Care Coordination has already been successfully established.

Care Coordination Cost-Benefit Analysis

Expense	Annual Budget Total Expense With Federal Match	Match Rate	Annual State Dollars
Personnel	$3,017,600	75/25	$754,000
Operating	377,200	50/50	188,600
TOTAL	$3,394,800		$943,000

Cost Savings - Care Coordination will be focusing on Medicaid's highest utilizers with chronic conditions; approximately 1200 patients statewide annually. These beneficiaries averaged over $35,000 per year per patient in total medical expenditures in FY2005 for an estimated $42 million. Projected cost-savings based on other States' (FL, NC, WA, IN, GA) interventions with this population range from 5% to 15% in the first 12 to 24 months. Based on these approximations, OVHA anticipates savings between $2.1 and $6.4 million. Most of the savings is expected to be realized in decreased emergency room and hospitalization expenditures as beneficiaries' health outcomes improve.

Initially, administrative costs may offset cost-savings in the first full year of implementation as the infrastructure and process is constructed. These costs, however, will become fixed as cost aversion strategies increase savings exponentially going forward. Additive cost savings will be realized as several of OVHA's quality initiatives

(Capitated Buprenorphine Program, Co-Management/Disease Management Project, the Vermont Blueprint for Health-related activities) begin to build on one another in the years to follow.

Section 6: Provider Taxes

There are five taxes aimed exclusively at providers that qualify under federal law as matching funds for the Medicaid program. To qualify, they must be uniformly applied to designated classes of Vermont providers and cannot exceed 6% of patient revenue.

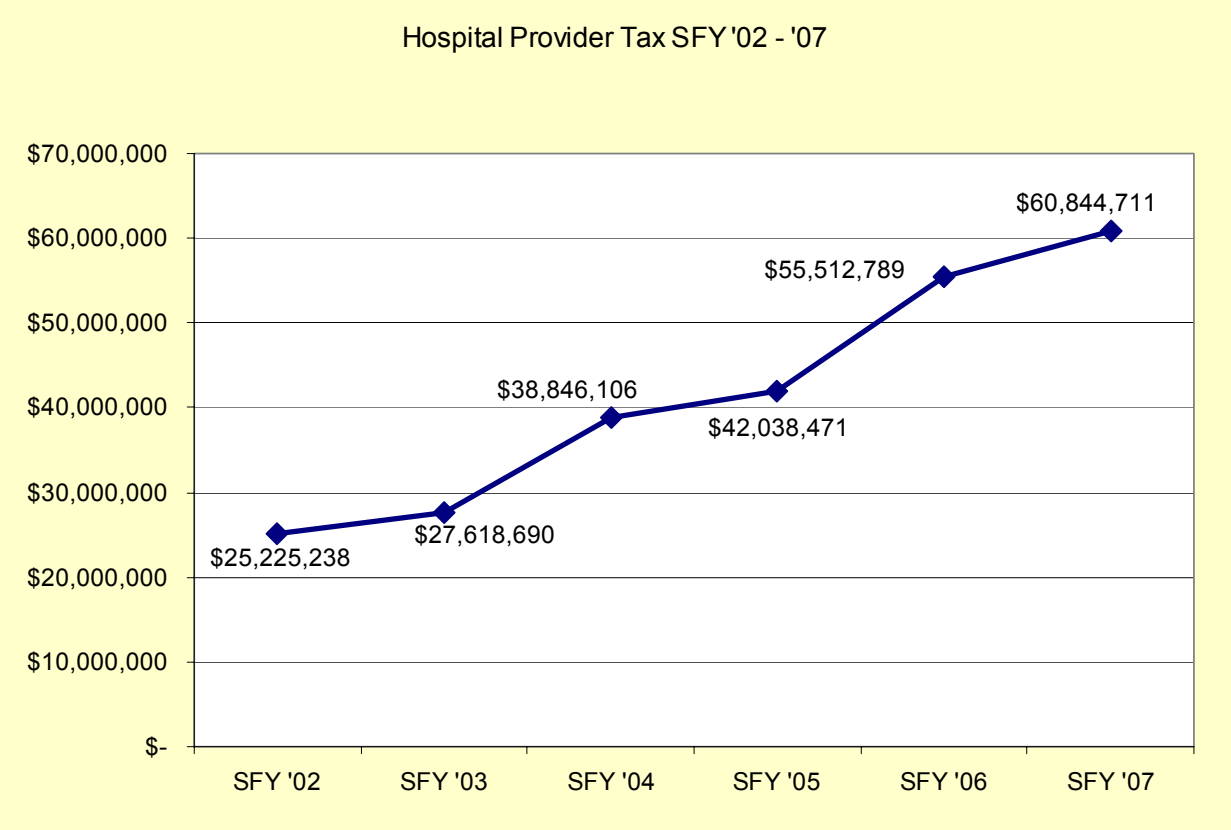
The *hospital tax* applies to their net patient service revenues which are taxed at 6%. The revenue from the hospital tax provides the general funds (GF) to support the disproportionate share hospital's (DSH) annual payments and the GF for a Vermont-only hospital rate increase (the remainder makes a substantial contribution to the general operations of the state's Medicaid program).

The *nursing home tax* is a per bed tax which is calculated annually to assure that it is close to, but does not exceed, the 6% maximum. This revenue is used to fund nursing home Medicaid payments.

The *Intermediate Care Facility for the Mentally Retarded (ICF-MR) tax* is set at 6% of the audited costs for the service. There is only one ICF-MR left in Vermont and this revenue helps fund that service.

The *home health agency tax* is based on "core" service revenues excluding Medicare revenues. The current tax is close to the 6% maximum. The revenue from this tax continues to support past rate increases for services offered by these agencies.

The *pharmacy tax* is set at $0.10 per prescription filled or refilled by a Vermont pharmacy. This revenue supports a portion of the dispensing fee paid for Medicaid prescriptions. For the SFY '06, the state is anticipating the collection of $603,499.64, based on revenues collected to-date.


Hospital Provider Tax SFY '02 - '07
$70,000,000
$60,000,000
$50,000,000
$40,000,000
$30,000,000
$20,000,000
$10,000,000
$-
$25,225,238
$27,618,690
$38,846,106
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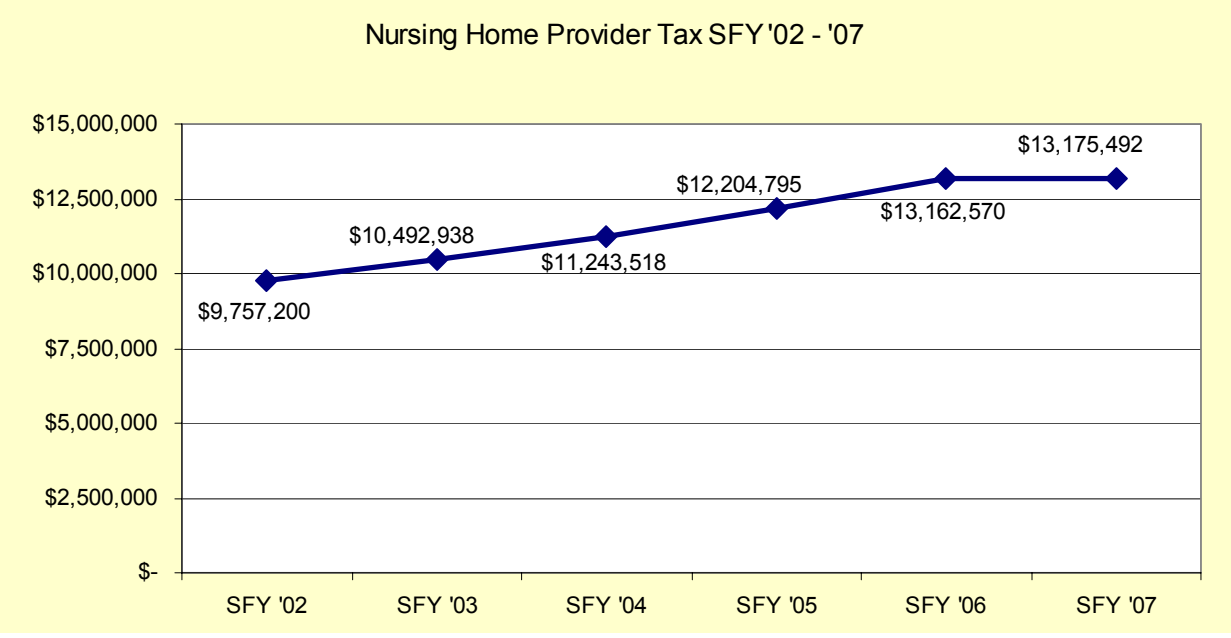
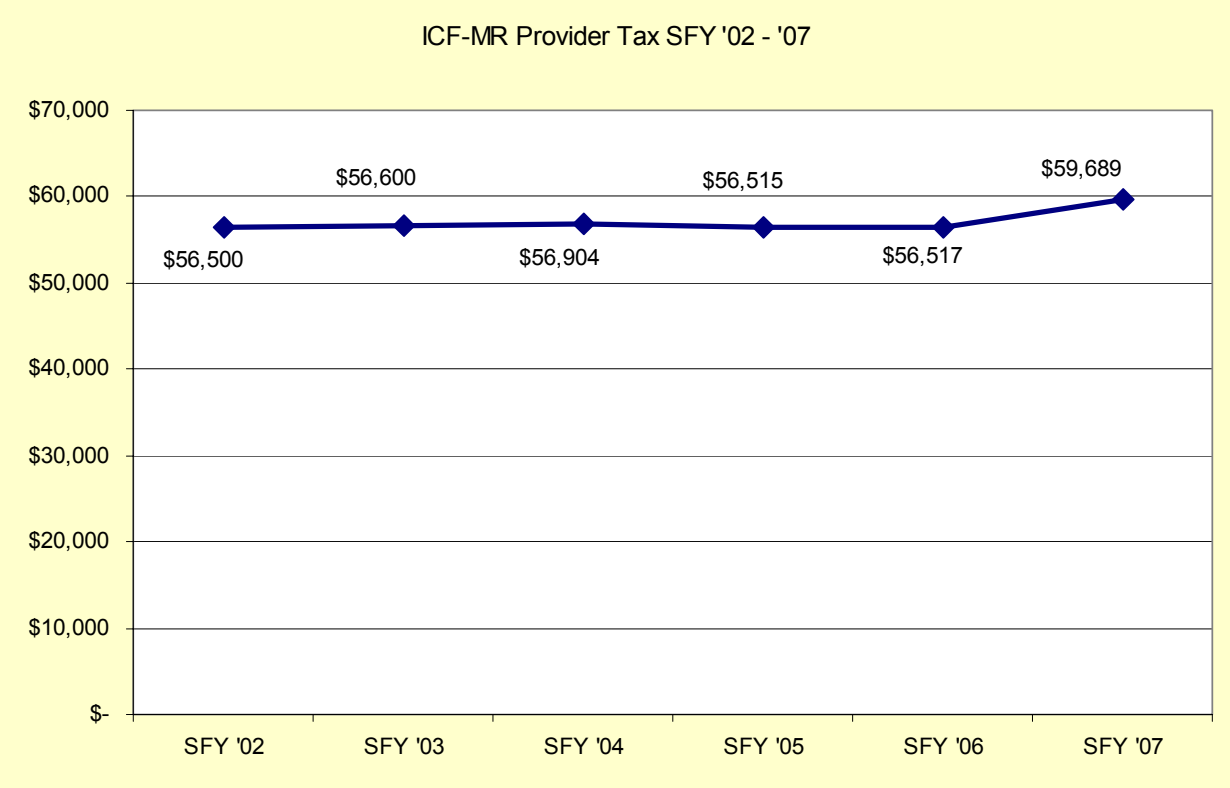
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07


Nursing Home Provider Tax SFY '02 - '07
$15,000,000
$12,500,000
$10,000,000
$7,500,000
$5,000,000
$2,500,000
$-
$9,757,200
$10,492,938
$11,243,518
$12,204,795
$13,162,570
$13,175,492
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07


ICF-MR Provider Tax SFY '02 - '07
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
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$56,500
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SFY '02
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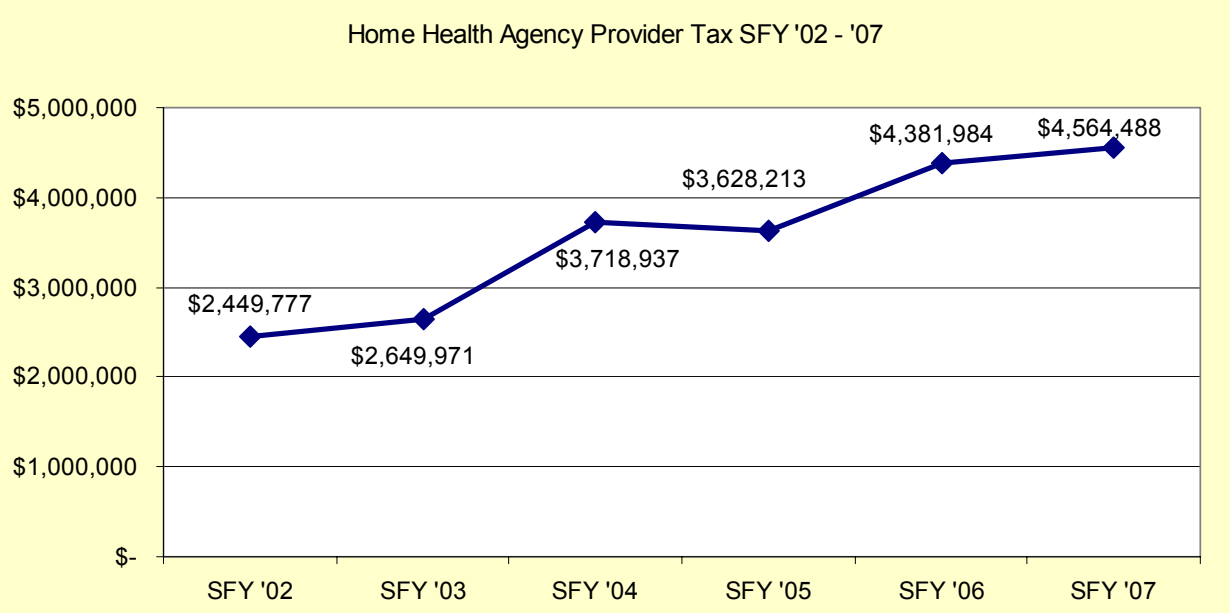
SFY '07


Home Health Agency Provider Tax SFY '02 - '07
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$-
$2,449,777
$2,649,971
$3,718,937
$3,628,213
$4,381,984
$4,564,488
SFY '02
SFY '03
SFY '04
SFY '05
SFY '06
SFY '07

Disproportionate Share Hospital (DSH)/Provider Tax Projections

OPTION A: No Provider Rate Increase; Reduce Tax Rate in SFY '09

	FFY '06				FFY '07				FFY '08				FFY '09				FFY '10			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	SFY '06				SFY '07				SFY '08				SFY '09				SFY '10			
Hospital Payments																				
DSH Payment	$35,981,664				$37,138,701	$19,115,486			$18,354,811	$34,420,297			$ 3,050,000	$37,797,753			$38,137,844			
Inpatient Rate Increment		$13,832,084				$14,039,565				$14,250,159				$14,463,911				$14,680,870		
Total		$49,813,748				$70,293,752				$67,025,267				$55,311,664				$52,818,714		
Provider Tax		$55,512,789				$60,844,711				$65,768,699				$54,061,664				$51,568,714		

OPTION B: Rate Increase to Offset 6% Tax

	FFY '06				FFY '07				FFY '08				FFY '09				FFY '10			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	SFY '06				SFY '07				SFY '08				SFY '09				SFY '10			
Hospital Payments																				
DSH Payment	$35,981,664				$37,138,701	$19,115,486			$18,354,811	$34,420,297			$ 3,050,000	$37,797,753			$38,137,844			
Inpatient Rate Increment		$13,832,084				$14,039,565				$14,250,159				$32,090,129				$41,251,947		
Total		$49,813,748				$70,293,752				$67,025,267				$72,937,882				$79,389,791		
Provider Tax		$55,512,789				$60,844,711				$65,768,699				$71,687,882				$78,139,791		

The five year projection assumes the Hospital Provider Tax will be at 6% to support second DSH payment, then will decrease to a lower provider tax rate in SFY '09.
Disproportionate Share Hospital (DSH) payments cannot exceed the federal cap for any Federal Fiscal Year.

Section 7: Employer Sponsored Insurance (ESI) Summary

Many Medicaid beneficiaries have access to employer-sponsored plans that provide affordable health insurance. It is estimated that up to 62% of employees between 100% and 199% of the FPL have access to employer-sponsored insurance. OVHA proposes to require enrollment in ESI for those with access to ESI and to provide a premium assistance subsidy so enrollees will not pay more than they presently pay. Premium assistance for current VHAP-eligible individuals will provide ESI coverage to an estimated 6,000 beneficiaries between 100% and 185% of the FPL. Additionally, uninsured Medicaid eligible individuals (0-150% FPL) may enroll in FY'07 as the program develops. Full enrollment in FY'08 includes 6,000 current VHAP eligible individuals and 6,119 uninsured Medicaid eligible individuals.

Participants in the premium assistance program will pay a premium to OVHA as do others in the VHAP program. The subsidy amounts will vary depending on federal poverty level, premium cost, and other out of pocket expenses. Subsidies, on average, will not be greater than what OVHA would spend providing care without ESI. The coverage offered under ESI for adults will provide core services (inpatient, outpatient, pharmacy, and preventative care). No wraparound coverage will be provided.

The Governor's recommend estimates FY'07 savings will be $4.8 million and $5.8 million for FY'08. Administrative expenditures required to implement the program are not included in the Governor's recommend.

Projected Impact SFY '07	Enrollment #'s	State Funds*
Medicaid Enrolled with ESI**	6,000	$ (4,856,000)
Uninsured Medicaid Eligible with ESI***	6,496	$ 3,200,000

Projected Impact SFY '08	Enrollment #'s	State Funds
Medicaid Enrolled with ESI	6,000	$ (5,851,818)
Uninsured Medicaid Eligible with ESI	6,119	$ 3,285,878

* Numbers in parenthesis () are savings.

The complete ESI report is included as Appendix 12.

Section 8: Clinical Quality Improvement

Every state is responsible for monitoring the integrity of its Medicaid program. Program integrity includes the provision of medically necessary and appropriate health care services, accurate reimbursement to qualified providers of those services, efficient administration of the program, and the prevention of inappropriate services and reimbursement. Maintaining the integrity of the Medicaid program is one way to contain costs without adversely affecting beneficiary services or provider reimbursement. A robust Surveillance and Utilization Review (SUR) unit can save the state Medicaid program significant dollars while improving the quality of care for its beneficiaries.

Since the inception of the OVHA SUR unit in September 2004, the unit has received over 170 referrals, resulting in eight referrals to the Medicaid Fraud and Residential Abuse unit and eleven referrals to law enforcement for potential prosecution. The SUR Unit is implementing a state of the art Fraud and Abuse Detection System (FADS).

This Fraud and Abuse Detection System (FADS) model will integrate with our existing Medicaid management information system. The FADS produces periodic reports from the claims processing system at pre-set intervals that will help unit staff to identify utilization trends. The FADS also has extensive reporting capability that will identify areas of focus that could benefit the OVHA's quality improvement process and enable the SUR unit to identify potential fraud, waste, or abuse. It is anticipated that the FADS will be operational by March 31, 2006.

Over 1800 procedures and services (totaling an estimated 1.2 million dollars) were denied during the prior authorization process from March 1, 2004 through February 28, 2005, because of failure to meet clinical criteria.

The prior authorization (PA) process helps to ensure clinical integrity by reviewing the medical need for services or items on a predetermined list, before they are provided. Each request receives nursing and/or physician review by the OVHA Clinical Review Unit. This review utilizes best practices and encourages quality of care while ensuring payment for appropriate services.

Section 9: Five-Year Total Medicaid Summary

Medicaid Five-Year Revenue Projections

To be Distributed at a Later Date

Section 10: OVHA Medicaid Bullet Sheet

- Laying the groundwork for SFY '07 the E-Board in July 2005 adopted new Per Member Per Month (PMPM) projections and new caseload estimates. The Budget Adjustment, As Passed by the House, appropriates the E-Board adopted figures with increases over actual SFY '05 as follows:

  - SFY '05 to SFY '06 Budget Adjustment
    $ 7,343,626 Gross / 1.16 %
    $18,067,584 State / 6.76%

- The number one factor driving the difference between gross and state spending growth is the impact of the new Medicare Pharmacy Program on spending. The SFY '06 Budget Adjustment to SFY '07 Governor's Recommend takes into account a full annualization of the Medicare changes.

  - SFY '06 Budget Adjustment to SFY '07 Governor's Recommend
    $34,533,867 Gross / 5.40%
    $25,047,958 State / 9.15%

- Pharmacy is the most confusing area this year. The impact of the Medicare Modernization Act (MMA) on Vermont's innumerable pharmacy programs has profound impacts on gross appropriations and overall trending patterns. Therefore, this budget document displays many charts and tables both without the MMA impact and with the MMA impact in order to highlight the importance of this shift in funding on program trends.

  - SFY '06 Appropriated w/o MMA to SFY '06 Budget Adjustment w/ MMA
    ($33,925,171) Gross / (17.33%)
  - Clawback – This is the State only payment made to the Federal Government by the State of Vermont to fund the Medicare Pharmacy Benefit.
    $ 22,670,044 State Funds

- The five largest categories of service (COS) in the Medicaid Budget and their respective dollar and percentage growth rates from SFY '06 Budget Adjustment to SFY '07 Governor's Recommend are:

  - Inpatient Hospital $ 2,004,580 Gross / 3.21%
  - Outpatient Hospital $ 1,805,782 Gross / 2.96%
  - Physician $ 2,240,140 Gross / 3.54%
  - Pharmacy ($31,886,397) Gross / (19.71%)
  - Long Term Care $11,157,965 Gross / 7.86%

- The two fastest growing Categories of Service from the SFY '06 Budget Adjustment to the SFY '07 Governor's Recommend are:
  - Personal Care Services $ 5,489,408 Gross / 38.18%
  - Transportation $ 2,449,349 Gross / 33.05%

- Disproportionate Share Hospital (DSH) payments experience what appears at first to be dramatic growth. This is quickly explained by one-time and timing issues. A portion of the hospital provider tax in SFY06 and SFY07 will be used to make a second DSH payment in SFY07. The 6% tax maximum limits the capacity to fund the second DSH completely in SFY '07. Therefore, the completion of the cycle will roll into a future SFY.

  $19,634,270 Gross / 53.61%

Table 1: Total Program Expenditures by State Fiscal Year

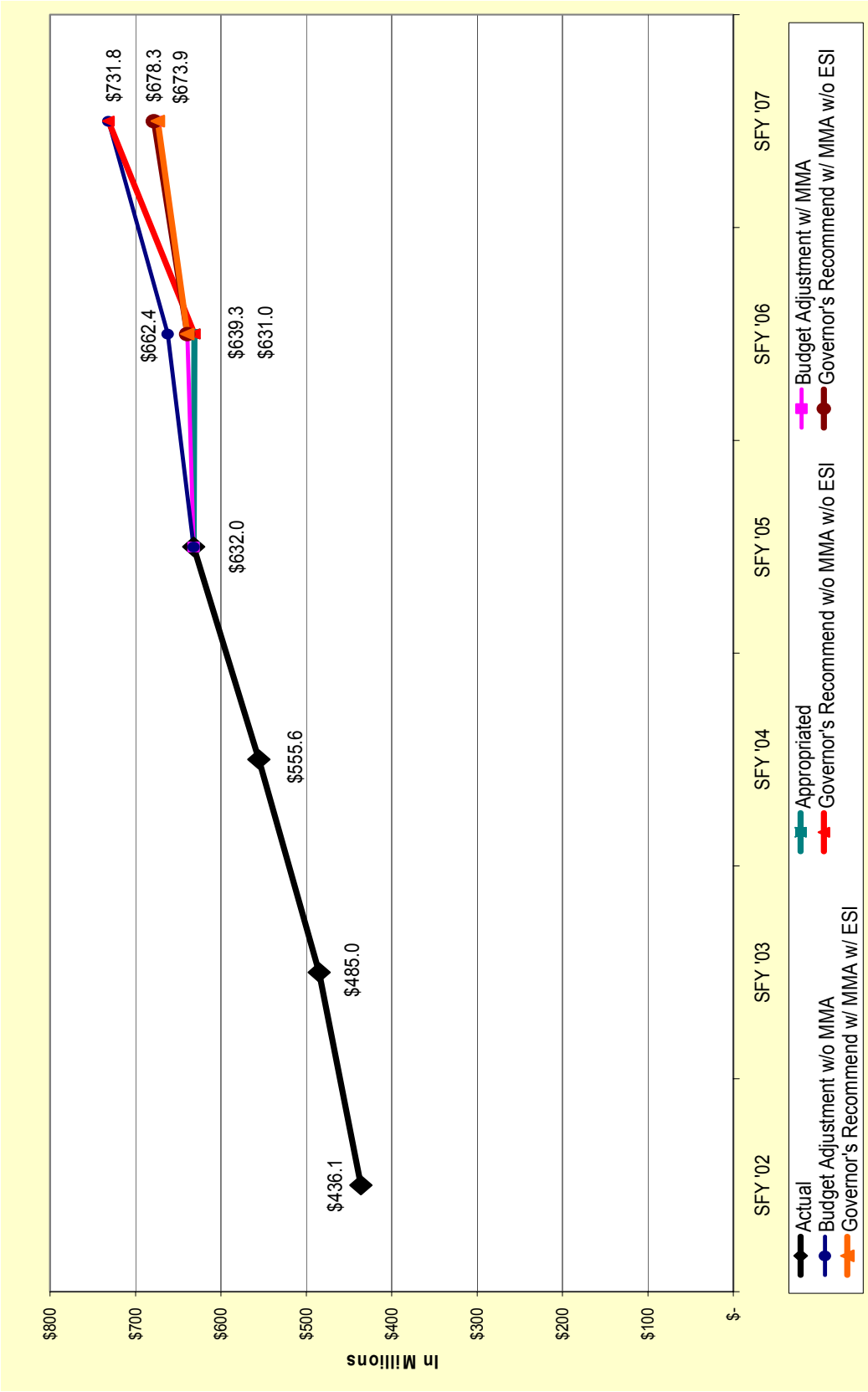


Table 2: Program Expenditures for SFY '07 - Governor's Recommend

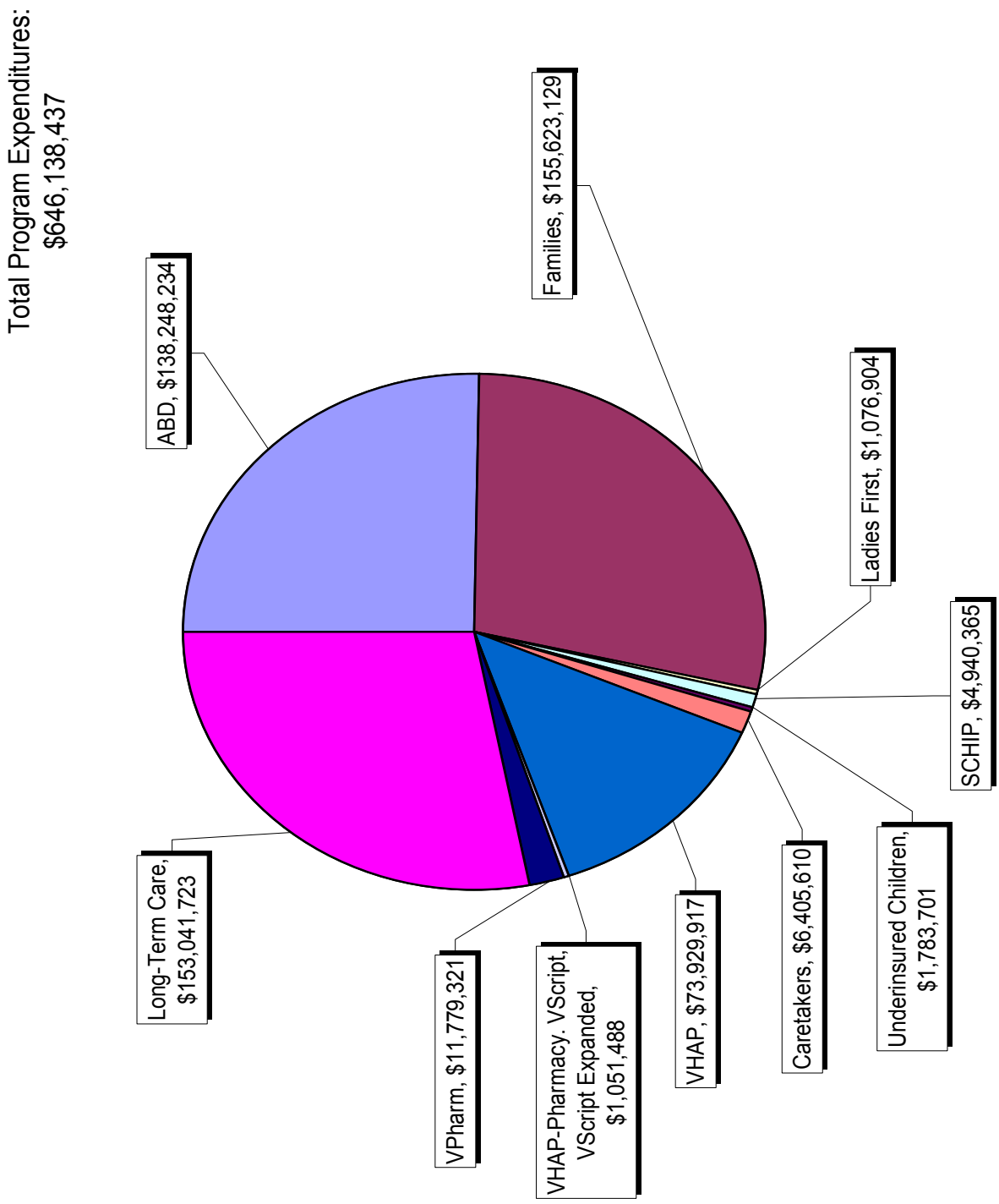


Table 3: Total Enrollment by State Fiscal Year

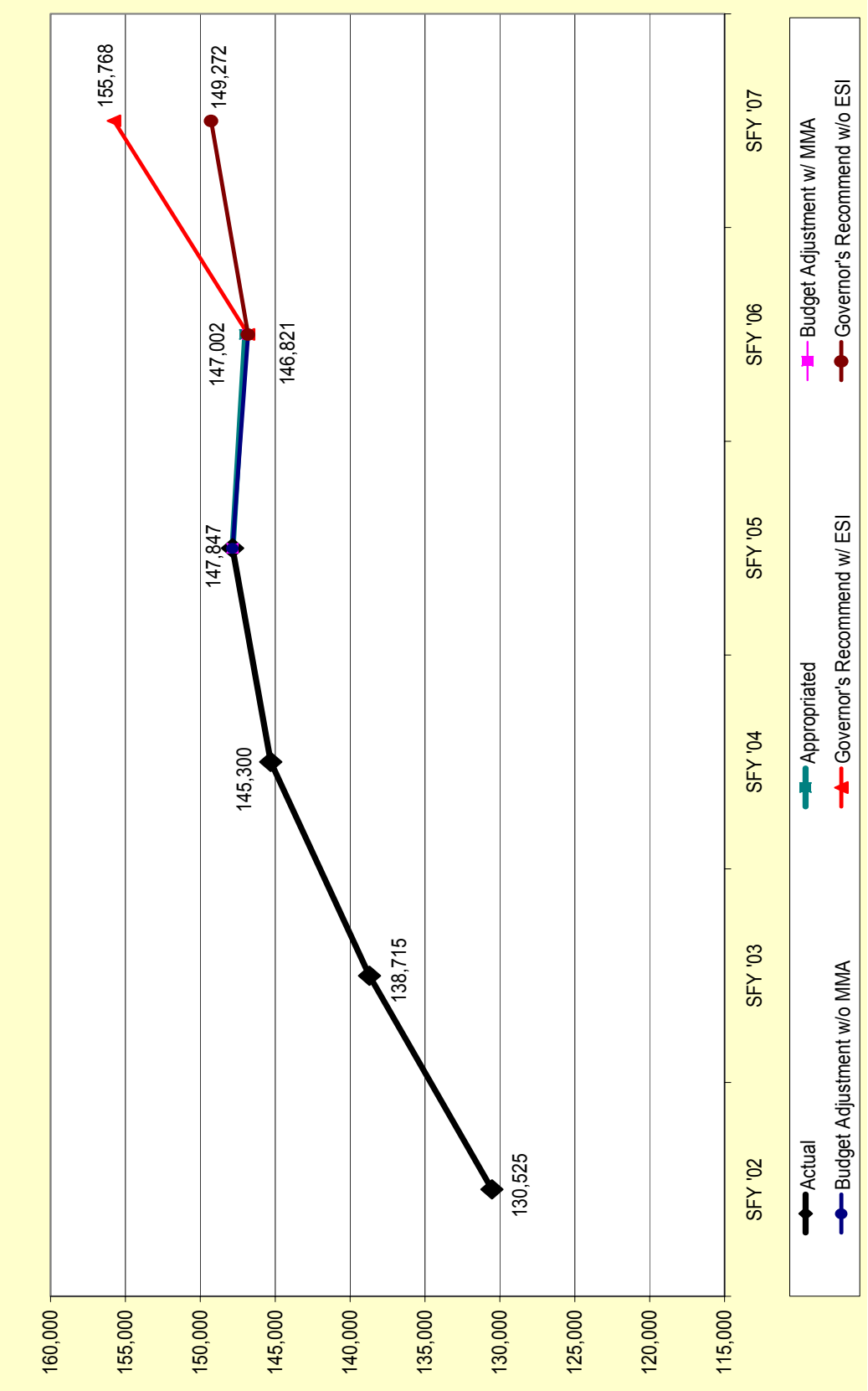


Table 4: Enrollment by SFY '07 Governor's Recommend

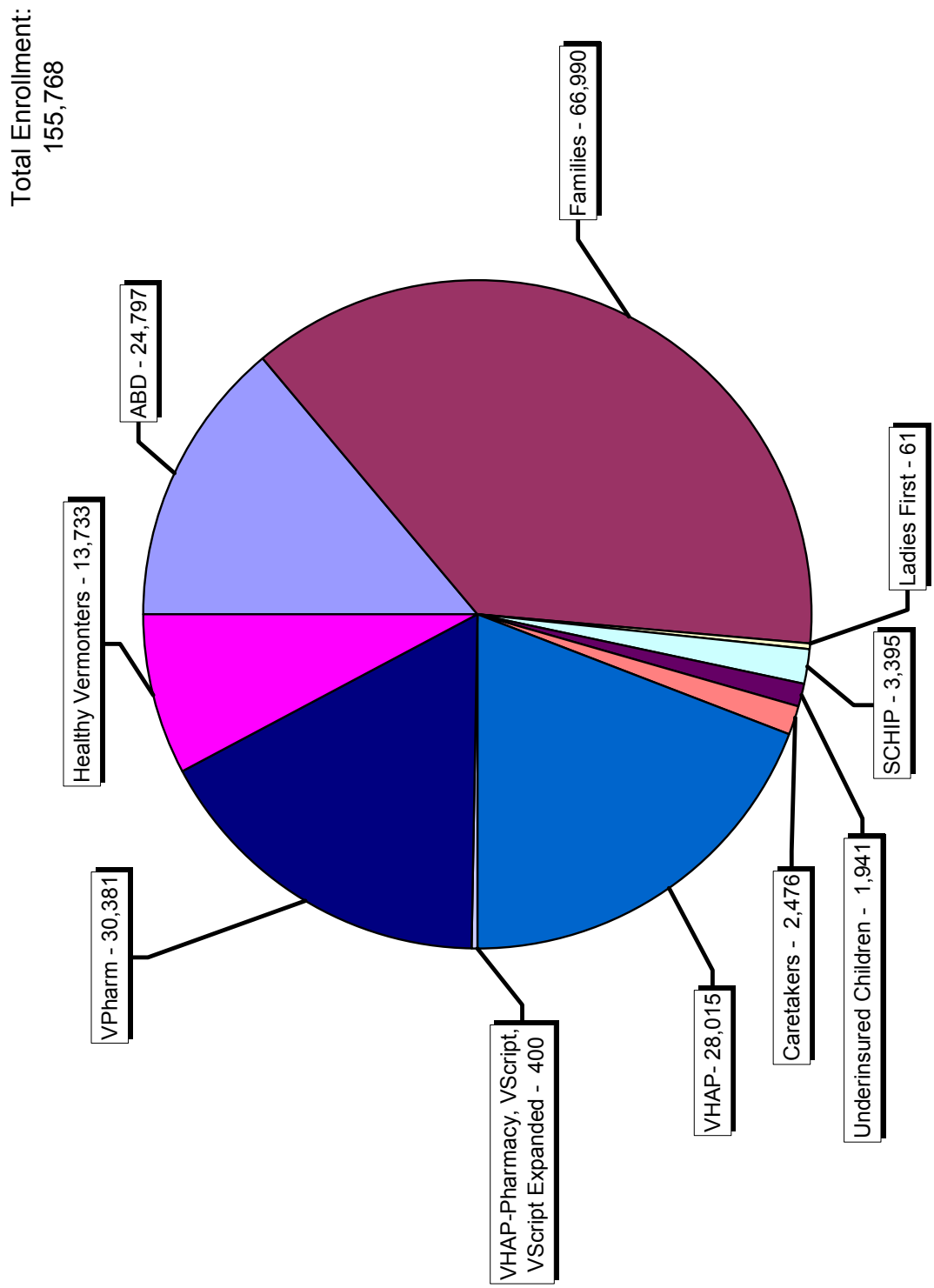


Table 5: Enrollment by State Fiscal Year by Enrollment Group

Enrollment Group	SFY' 05	SFY '06 Appropriated	SFY '06 Projected w/o MMA	SFY '06 Projected w/MMA	SFY '07 Projected	SFY '07 Gov, Rec.
ABD	23,643	24,305	24,305	*24,305*	24,797	24,797
Families	67,719	68,435	67,288	*67,288*	66,990	66,990
Ladies First	64	68	66	*66*	61	61
SCHIP	3,141	2,997	3,125	*3,125*	3,395	3,395
Underinsured Children	1,766	1,774	1,972	*1,972*	1,941	1,941
Caretakers	2,376	2,458	2,397	*2,397*	2,476	2,476
VHAP	22,081	21,250	21,953	*21,953*	21,519	28,015
VHAP-Pharmacy	8,446	8,818	8,818	*8,818*	0	0
VScript	2,741	2,847	2,847	*2,847*	0	0
VScript expanded	2,615	2,695	2,695	*2,695*	0	0
VPharm	0	0	0	30,381	30,381	30,381
VHAP-Pharmacy,VScript,VScript Expanded	0	0	0	400	400	400
Healthy Vermonters	13,255	11,355	11,355	*11,355*	13,733	13,733
Total Caseload	147,847	147,002	146,821	*146,821*	149,272	155,768

SFY '06 Projected w/MMA **Total Caseload** is reduced by 30,781 VPharm Enrollees as they are already included in the ABD, VHAP-Pharmacy, VScript, and VScript Expanded enrollment counts.
SFY '07 Projected Total Caseload is reduced by 16,421 VPharm Enrollees as they are already included in the ABD Enrollment Count.
SFY '07 Gov. Rec. Total Caseload is reduced by 16,421 VPharm Enrollees as they are already included in the ABD Enrollment Count.

Enrollment Group	Percentage Change				
	SFY '05 - SFY '06 Appropriated	SFY '05 - SFY '06 Projected w/o MMA	SFY '05 - SFY '06 Projected w/MMA	SFY '06 Appropriated - SFY '07 Projected	SFY '06 Appropriated - SFY '07 Gov. Rec.
ABD	2.8%	2.8%	2.8%	2.0%	2.0%
Families	1.1%	-0.6%	-0.6%	-2.1%	-2.1%
Ladies First	6.3%	3.1%	3.1%	-10.3%	-10.3%
SCHIP	-4.6%	-0.5%	-0.5%	13.3%	13.3%
Underinsured Children	0.5%	11.7%	11.7%	9.4%	9.4%
Caretakers	3.5%	0.9%	0.9%	0.7%	0.7%
VHAP	-3.8%	-0.6%	-0.6%	1.3%	31.8%
VHAP-Pharmacy	4.4%	4.4%	4.4%		
VScript	3.9%	3.9%	3.9%		
VScript expanded	3.1%	3.1%	3.1%		
VPharm					
VHAP-Pharmacy,VScript,VScript Expanded					
Healthy Vermonters	-14.3%	-14.3%	-14.3%	20.9%	20.9%
Total Percent(%) Change	-0.6%	-0.7%	-0.7%	1.5%	6.0%

Table 6: Enrollment Growth Trend July 1994 - December 2005

Located in Back Pocket of Binder

Table 7: Cost Comparison of SFY '04 through SFY '07 – Governor's Recommend, without MMA and without ESI

	SFY 2005 Actual Final			SFY 2006 Appropriated			SFY 2006 Budget Adjustment w/o MMA			SFY 2007 Gov Rec w/o MMA (ABD), w/o ESI		
	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM
Program Costs												
ABD	23,643	$ 161,792,698	$ 570.26	24,305	$ 166,960,545	$ 572.45	24,305	$ 177,566,989	$ 608.82	24,797	$ 191,745,052	$ 644.38
Families	67,719	$ 142,207,467	$ 175.00	68,435	$ 138,524,716	$ 168.68	67,288	$ 148,628,426	$ 184.07	66,990	$ 155,623,129	$ 193.59
Ladies First	64	$ 653,877	$ 851.40	68	$ 1,231,006	$ 1,508.59	66	$ 1,317,334	$ 1,663.30	61	$ 1,076,904	$ 1,471.18
Schip	3,141	$ 4,045,623	$ 107.33	2,997	$ 3,928,372	$ 109.23	3,125	$ 4,181,625	$ 111.51	3,395	$ 4,940,365	$ 121.27
Underinsured Children	1,766	$ 1,196,600	$ 56.46	1,774	$ 1,296,036	$ 60.88	1,972	$ 1,627,847	$ 68.79	1,941	$ 1,783,701	$ 76.58
Caretakers	2,376	$ 4,853,340	$ 170.22	2,458	$ 5,138,500	$ 174.21	2,397	$ 5,699,874	$ 198.16	2,476	$ 6,405,610	$ 215.59
Total Traditional	98,709	$ 314,749,604	$ 265.72	100,037	$ 317,079,174	$ 264.13	99,153	$ 339,022,094	$ 284.93	99,660	$ 361,574,761	$ 302.34
VHAP Uninsured	22,081	$ 73,431,832	$ 277.13	21,250	$ 60,341,115	$ 236.63	21,953	$ 67,547,625	$ 256.41	21,519	$ 77,951,286	$ 301.87
VHAP-Pharmacy	8,446	$ 19,157,825	$ 189.02	8,818	$ 20,502,679	$ 193.76	8,818	$ 21,714,821	$ 205.21		$ -	
VScript	2,741	$ 6,192,507	$ 188.27	2,847	$ 6,054,407	$ 177.22	2,847	$ 6,411,197	$ 187.66		$ -	
VScript Expanded	2,615	$ 5,985,715	$ 190.75	2,695	$ 5,688,023	$ 175.88	2,695	$ 6,024,247	$ 186.28		$ -	
VPharm										30,381	$ 11,779,321	$ 32.31
VHAP-Pharmacy, VScript & VScript Expanded										400	$ 1,051,488	$ 219.06
ESI Transition												
ESI New												
Physician Reimbursement Increase												
Health Care Other												
Total	35,883	$ 104,767,880	$ 230.66	35,610	$ 92,586,223	$ 216.67	36,313	$ 101,697,890	$ 233.38	35,879	$ 90,782,095	$ 210.85
PDP/Healthy Vermonters Program	13,255	$ -	$ -	11,355	$ -	$ -	11,355	$ -	$ -	13,733	$ -	$ -
Total Program Costs	147,847	$ 419,517,484	$ 236.46	147,002	$ 409,665,398	$ 232.23	146,821	$ 440,719,984	$ 250.15	149,272	$ 452,356,856	$ 252.54
Other Costs												
DSH	n/a	$ 34,793,164	n/a	n/a	$ 36,619,917	n/a	n/a	$ 36,619,917	n/a	n/a	$ 56,254,187	n/a
Legal Aid	n/a	$ 458,383	n/a	n/a	$ 384,375	n/a	n/a	$ 384,375	n/a	n/a	$ 395,906	n/a
Rate Setting	n/a	$ -	n/a	n/a	$ 620,468	n/a	n/a	$ 620,468	n/a	n/a	$ 651,491	n/a
DDMHS Transfer of General Funds	n/a	$ -	n/a	n/a	$ -	n/a	n/a	$ -	n/a	n/a	$ -	n/a
Lund Home Family Ctr Retro PNMI	n/a	$ 523,624	n/a	n/a	$ 625,000	n/a	n/a	$ 625,000	n/a	n/a	$ 625,000	n/a
Buy-In	n/a	$ 14,204,050	n/a	n/a	$ 13,241,683	n/a	n/a	$ 13,241,683	n/a	n/a	$ 18,268,507	n/a
Clawback										n/a	$ 22,670,044	n/a
Other		$ -			$ -			$ -		n/a	$ -	n/a
Total Other		$ 49,979,221			$ 51,491,443			$ 51,491,443			$ 98,865,135	
Total Medicaid w/o Long Term Care	147,847	$ 469,496,705	$ 264.63	147,002	$ 461,156,841	$ 261.42	146,821	$ 492,211,428	$ 279.37	149,272	$ 551,221,992	$ 307.73
Long Term Care Costs	n/a	$ 140,171,168	n/a	n/a	$ 141,883,758	n/a	n/a	$ 142,283,617	n/a	n/a	$ 153,041,723	n/a
Total	147,847	$ 609,667,874	$ 343.64	147,002	$ 603,040,599	$ 341.86	146,821	$ 634,495,045	$ 360.13	149,272	$ 704,263,715	$ 393.17
Operating Expenses												
Fiscal Intermediary - EDS		$ 8,217,754			$ 9,071,232			$ 9,071,232			$ 8,633,903	
Fiscal Intermediary - EDS HIPPA		$ 3,671,495			$ -			$ -			$ -	
Pharmacy Program Management - First Health		$ 2,921,920			$ 3,052,920			$ 3,052,920			$ -	
MMIS - National System Research (CIBER)		$ 1,483,169			$ -			$ -			$ 420,000	
MMIS - Fox System		$ -			$ -			$ -			$ -	
MMIS - Consultant		$ -			$ -			$ -			$ -	
MMIS - Competitive Computing, Inc.		$ 6,141			$ -			$ -			$ -	
Health Care P/S Contract - Maximus		$ 2,291,959			$ 2,068,372			$ 2,068,372			$ 2,143,223	
Health Care P/S Contract - Ombudsman		$ 226,415			$ 217,000			$ 217,000			$ 230,216	
Health Care P/S Contract - Pacific Health Policy		$ 572,493			$ 587,860			$ 587,860			$ 626,228	
Health Care P/S Contract - MedMetrics		$ -			$ -			$ -			$ 1,947,259	
Health Care P/S Contract - Delmarva		$ 127,931			$ -			$ -			$ -	
Health Care P/S Contract - UVM VChip		$ -			$ -			$ -			$ -	
Health Care P/S Contract - UVM EQRO		$ 290,276			$ 257,744			$ 257,744			$ 200,000	
Health Care P/S Contract - PSI CSME		$ 1,203,012			$ 564,225			$ 564,225			$ 525,000	
Health Care P/S Contract - PSI MMA		$ -			$ 1,200,000			$ 1,200,000			$ 1,200,000	
Health Care P/S Contract - Atlantic Mkt Research		$ 9,859			$ -			$ -			$ -	
Health Care P/S Contract - Medical Consultant		$ -			$ -			$ -			$ -	
Health Care P/S Contract - Legal Consultant		$ -			$ -			$ -			$ -	
Health Care P/S Contract - Anthem of NH		$ 61,250			$ -			$ -			$ -	
Child Health Outreach Grants		$ -			$ -			$ -			$ -	
Vermont Democracy Fund Grant for PCA		$ -			$ -			$ -			$ -	
Health Care Miscellaneous Expenses		$ 1,234,386			$ -			$ -			$ -	
Health Care P/S Contract - Miscellaneous		$ -			$ 631,051			$ 631,051			$ 889,647	
OVHA Operating Expense/Personnel Services		$ -			$ 5,097,808			$ 5,097,808			$ 7,587,955	
Quality		$ -			$ 5,196,246			$ 5,196,246			$ 3,126,559	
Total Direct Administrative Costs		$ 22,318,060	$ 12.58		$ 27,944,458	$ 15.84		$ 27,944,458	$ 15.86		$ 27,529,990	$ 15.37
Total Program and Administrative Costs	147,847	$ 631,985,934	$ 356.22	147,002	$ 630,985,057	$ 357.70	146,821	$ 662,439,503	$ 375.99	149,272	$ 731,796,641	$ 408.54

Table 8: Cost Comparison of SFY '04 through SFY '07 – Governor's Recommend, with MMA and without ESI

	SFY 2005 Actual Final			SFY 2006 Appropriated			SFY 2006 Budget Adjustment w/ MMA			SFY 2007 Gov Rec w/ MMA, No ESI		
	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM
Program Costs												
ABD	23,643	$ 161,792,698	$ 570.26	24,305	$ 166,960,545	$ 572.45	24,305	$ 153,615,924	$ 526.70	24,797	$ 138,248,234	$ 464.60
Families	67,719	$ 142,207,467	$ 175.00	68,435	$ 138,524,716	$ 168.68	67,288	$ 148,628,426	$ 184.07	66,990	$ 155,623,129	$ 193.59
Ladies First	64	$ 653,877	$ 851.40	68	$ 1,231,006	$ 1,508.59	66	$ 1,317,334	$ 1,663.30	61	$ 1,076,904	$ 1,471.18
Schip	3,141	$ 4,045,623	$ 107.33	2,997	$ 3,928,372	$ 109.23	3,125	$ 4,181,625	$ 111.51	3,395	$ 4,940,365	$ 121.27
Underinsured Children	1,766	$ 1,196,600	$ 56.46	1,774	$ 1,296,036	$ 60.88	1,972	$ 1,627,847	$ 68.79	1,941	$ 1,783,701	$ 76.58
Caretakers	2,376	$ 4,853,340	$ 170.22	2,458	$ 5,138,500	$ 174.21	2,397	$ 5,699,874	$ 198.16	2,476	$ 6,405,610	$ 215.59
Total Traditional	98,709	$ 314,749,604	$ 265.72	100,037	$ 317,079,174	$ 264.13	99,153	$ 315,071,029	$ 264.80	99,660	$ 308,077,943	$ 257.61
VHAP Uninsured	22,081	$ 73,431,832	$ 277.13	21,250	$ 60,341,115	$ 236.63	21,953	$ 67,547,625	$ 256.41	21,519	$ 77,951,286	$ 301.87
VHAP-Pharmacy	8,446	$ 19,157,825	$ 189.02	8,818	$ 20,502,679	$ 193.76	8,818	$ 10,857,410	$ 205.21		$ -	
VScript	2,741	$ 6,192,507	$ 188.27	2,847	$ 6,054,407	$ 177.22	2,847	$ 3,205,599	$ 187.66		$ -	
VScript Expanded	2,615	$ 5,985,715	$ 190.75	2,695	$ 5,688,023	$ 175.88	2,695	$ 3,012,123	$ 186.28		$ -	
VPharm							30,381	$ 4,942,082	$ 27.11	30,381	$ 11,779,321	$ 32.31
VHAP-Pharmacy, VScript & VScript Expanded							400	$ 471,942	$ 196.64	400	$ 1,051,488	$ 219.06
ESI Transition												
ESI New												
Physician Reimbursement Increase												
Health Care Other												
Total	35,883	$ 104,767,880	$ 230.66	35,610	$ 92,586,223	$ 216.67	36,313	$ 90,036,781	$ 206.62	35,879	$ 90,782,095	$ 210.85
PDP/Healthy Vermonters Program	13,255	$ -	$ -	11,355	$ -	$ -	11,355	$ -	$ -	13,733	$ -	$ -
Total Program Costs	147,847	$ 419,517,484	$ 236.46	147,002	$ 409,665,398	$ 232.23	146,821	$ 405,107,810	$ 229.93	149,272	$ 398,860,039	$ 222.67
Other Costs												
DSH	n/a	$ 34,793,164	n/a	n/a	$ 36,619,917	n/a	n/a	$ 36,619,917	n/a	n/a	$ 56,254,187	n/a
Legal Aid	n/a	$ 458,383	n/a	n/a	$ 384,375	n/a	n/a	$ 384,375	n/a	n/a	$ 395,906	n/a
Rate Setting	n/a	$ -	n/a	n/a	$ 620,468	n/a	n/a	$ 620,468	n/a	n/a	$ 651,491	n/a
DDMHS Transfer of General Funds	n/a	$ -	n/a	n/a	$ -	n/a	n/a	$ -	n/a	n/a	$ -	n/a
Lund Home Family Ctr Retro PNMI	n/a	$ 523,624	n/a	n/a	$ 625,000	n/a	n/a	$ 625,000	n/a	n/a	$ 625,000	n/a
Buy-In	n/a	$ 14,204,050	n/a	n/a	$ 13,241,683	n/a	n/a	$ 17,054,079	n/a	n/a	$ 18,268,507	n/a
Clawback							n/a	$ 8,689,836	n/a	n/a	$ 22,670,044	n/a
Other		$ -			$ -		n/a	$ -	n/a	n/a	$ -	n/a
Total Other		$ 49,979,221			$ 51,491,443			$ 63,993,675			$ 98,865,135	
Total Medicaid w/o Long Term Care	147,847	$ 469,496,705	$ 264.63	147,002	$ 461,156,841	$ 261.42	146,821	$ 469,101,485	$ 266.25	149,272	$ 497,725,174	$ 277.86
Long Term Care Costs	n/a	$ 140,171,168	n/a	n/a	$ 141,883,758	n/a	n/a	$ 142,283,617	n/a	n/a	$ 153,041,723	n/a
Total	147,847	$ 609,667,874	$ 343.64	147,002	$ 603,040,599	$ 341.86	146,821	$ 611,385,102	$ 347.01	149,272	$ 650,766,897	$ 363.30
Operating Expenses												
Fiscal Intermediary - EDS		$ 8,217,754			$ 9,071,232			$ 9,071,232			$ 8,633,903	
Fiscal Intermediary - EDS HIPPA		$ 3,671,495			$ -			$ -			$ -	
Pharmacy Program Management - First Health		$ 2,921,920			$ 3,052,920			$ 3,052,920			$ -	
MMIS - National System Research (CIBER)		$ 1,483,169			$ -			$ -			$ 420,000	
MMIS - Fox System		$ -			$ -			$ -			$ -	
MMIS - Consultant		$ -			$ -			$ -			$ -	
MMIS - Competitive Computing, Inc.		$ 6,141			$ -			$ -			$ -	
Health Care P/S Contract - Maximus		$ 2,291,959			$ 2,068,372			$ 2,068,372			$ 2,143,223	
Health Care P/S Contract - Ombudsman		$ 226,415			$ 217,000			$ 217,000			$ 230,216	
Health Care P/S Contract - Pacific Health Policy		$ 572,493			$ 587,860			$ 587,860			$ 626,228	
Health Care P/S Contract - MedMetrics		$ -									$ 1,947,259	
Health Care P/S Contract - Delmarva		$ 127,931			$ -			$ -			$ -	
Health Care P/S Contract - UVM VChip		$ -			$ -			$ -			$ -	
Health Care P/S Contract - UVM EQRO		$ 290,276			$ 257,744			$ 257,744			$ 200,000	
Health Care P/S Contract - PSI CSME		$ 1,203,012			$ 564,225			$ 564,225			$ 525,000	
Health Care P/S Contract - PSI MMA		$ -			$ 1,200,000			$ 1,200,000			$ 1,200,000	
Health Care P/S Contract - Atlantic Mkt Research		$ 9,859			$ -			$ -			$ -	
Health Care P/S Contract - Medical Consultant		$ -			$ -			$ -			$ -	
Health Care P/S Contract - Legal Consultant		$ -			$ -			$ -			$ -	
Health Care P/S Contract - Anthem of NH		$ 61,250			$ -			$ -			$ -	
Child Health Outreach Grants		$ -			$ -			$ -			$ -	
Vermont Democracy Fund Grant for PCA		$ -			$ -			$ -			$ -	
Health Care Miscellaneous Expenses		$ 1,234,386			$ -			$ -			$ -	
Health Care P/S Contract - Miscellaneous		$ -			$ 631,051			$ 631,051			$ 889,647	
OVHA Operating Expense/Personnel Services		$ -			$ 5,097,808			$ 5,097,808			$ 7,587,955	
Quality		$ -			$ 5,196,246			$ 5,196,246			$ 3,126,559	
Total Direct Administrative Costs		$ 22,318,060	$ 12.58		$ 27,944,458	$ 15.84		$ 27,944,458	$ 15.86		$ 27,529,990	$ 15.37
Total Program and Administrative Costs	147,847	$ 631,985,934	$ 356.22	147,002	$ 630,985,057	$ 357.70	146,821	$ 639,329,560	$ 362.87	149,272	$ 678,296,887	$ 378.67

Table 9: Cost Comparison of SFY '04 through SFY '07 – Governor's Recommend, with MMA and with ESI

	SFY 2005 Actual Final			SFY 2006 Appropriated			SFY 2006 Budget Adjustment w/ MMA			SFY 2007 Gov Rec w/MMA, ESI		
	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM
Program Costs												
ABD	23,643	$ 161,792,698	$ 570.26	24,305	$ 166,960,545	$ 572.45	24,305	$ 153,615,924	$ 526.70	24,797	$ 138,248,234	$ 464.60
Families	67,719	$ 142,207,467	$ 175.00	68,435	$ 138,524,716	$ 168.68	67,288	$ 148,628,426	$ 184.07	66,990	$ 155,623,129	$ 193.59
Ladies First	64	$ 653,877	$ 851.40	68	$ 1,231,006	$ 1,508.59	66	$ 1,317,334	$ 1,663.30	61	$ 1,076,904	$ 1,471.18
Schip	3,141	$ 4,045,623	$ 107.33	2,997	$ 3,928,372	$ 109.23	3,125	$ 4,181,625	$ 111.51	3,395	$ 4,940,365	$ 121.27
Underinsured Children	1,766	$ 1,196,600	$ 56.46	1,774	$ 1,296,036	$ 60.88	1,972	$ 1,627,847	$ 68.79	1,941	$ 1,783,701	$ 76.58
Caretakers	2,376	$ 4,853,340	$ 170.22	2,458	$ 5,138,500	$ 174.21	2,397	$ 5,699,874	$ 198.16	2,476	$ 6,405,610	$ 215.59
Total Traditional	98,709	$ 314,749,604	$ 265.72	100,037	$ 317,079,174	$ 264.13	99,153	$ 315,071,029	$ 264.80	99,660	$ 308,077,943	$ 257.61
VHAP Uninsured	22,081	$ 73,431,832	$ 277.13	21,250	$ 60,341,115	$ 236.63	21,953	$ 67,547,625	$ 256.41	21,519	$ 77,951,286	$ 301.87
VHAP-Pharmacy	8,446	$ 19,157,825	$ 189.02	8,818	$ 20,502,679	$ 193.76	8,818	$ 10,857,410	$ 205.21		$ -	
VScript	2,741	$ 6,192,507	$ 188.27	2,847	$ 6,054,407	$ 177.22	2,847	$ 3,205,599	$ 187.66		$ -	
VScript Expanded	2,615	$ 5,985,715	$ 190.75	2,695	$ 5,688,023	$ 175.88	2,695	$ 3,012,123	$ 186.28		$ -	
VPharm							30,381	$ 4,942,082	$ 27.11	30,381	$ 11,779,321	$ 32.31
VHAP-Pharmacy, VScript & VScript Expanded							400	$ 471,942	$ 196.64	400	$ 1,051,488	$ 219.06
ESI Transition										6,000	$ (11,792,132)	$ (163.78)
ESI New										6,496	$ 7,770,763	$ 99.69
Physician Reimbursement Increase											$ 2,428,363	
Health Care Other											$ (3,035,454)	
Total	35,883	$ 104,767,880	$ 230.66	35,610	$ 92,586,223	$ 216.67	36,313	$ 90,036,781	$ 206.62	42,375	$ 86,153,635	$ 169.43
PDP/Healthy Vermonters Program	13,255	$ -	$ -	11,355	$ -	$ -	11,355	$ -	$ -	13,733	$ -	$ -
Total Program Costs	147,847	$ 419,517,484	$ 236.46	147,002	$ 409,665,398	$ 232.23	146,821	$ 405,107,810	$ 229.93	155,768	$ 394,231,578	$ 210.91
Other Costs												
DSH	n/a	$ 34,793,164	n/a	n/a	$ 36,619,917	n/a	n/a	$ 36,619,917	n/a	n/a	$ 56,254,187	n/a
Legal Aid	n/a	$ 458,383	n/a	n/a	$ 384,375	n/a	n/a	$ 384,375	n/a	n/a	$ 395,906	n/a
Rate Setting	n/a	$ -	n/a	n/a	$ 620,468	n/a	n/a	$ 620,468	n/a	n/a	$ 651,491	n/a
DDMHS Transfer of General Funds	n/a	$ -	n/a	n/a	$ -	n/a	n/a	$ -	n/a	n/a	$ -	n/a
Lund Home Family Ctr Retro PNMI	n/a	$ 523,624	n/a	n/a	$ 625,000	n/a	n/a	$ 625,000	n/a	n/a	$ 625,000	n/a
Buy-In	n/a	$ 14,204,050	n/a	n/a	$ 13,241,683	n/a	n/a	$ 17,054,079	n/a	n/a	$ 18,268,507	n/a
Clawback							n/a	$ 8,689,836	n/a	n/a	$ 22,670,044	n/a
Other		$ -			$ -		n/a	$ -	n/a	n/a	$ -	n/a
Total Other		$ 49,979,221			$ 51,491,443			$ 63,993,675			$ 98,865,135	
Total Medicaid w/o Long Term Care	147,847	$ 469,496,705	$ 264.63	147,002	$ 461,156,841	$ 261.42	146,821	$ 469,101,485	$ 266.25	155,768	$ 493,096,714	$ 263.80
Long Term Care Costs	n/a	$ 140,171,168	n/a	n/a	$ 141,883,758	n/a	n/a	$ 142,283,617	n/a	n/a	$ 153,041,723	n/a
Total	147,847	$ 609,667,874	$ 343.64	147,002	$ 603,040,599	$ 341.86	146,821	$ 611,385,102	$ 347.01	155,768	$ 646,138,437	$ 345.67
Operating Expenses												
Fiscal Intermediary - EDS		$ 8,217,754			$ 9,071,232			$ 9,071,232			$ 8,633,903	
Fiscal Intermediary - EDS HIPPA		$ 3,671,495			$ -			$ -			$ -	
Pharmacy Program Management - First Health		$ 2,921,920			$ 3,052,920			$ 3,052,920			$ -	
MMIS - National System Research (CIBER)		$ 1,483,169			$ -			$ -			$ 420,000	
MMIS - Fox System		$ -			$ -			$ -			$ -	
MMIS - Consultant		$ -			$ -			$ -			$ -	
MMIS - Competitive Computing, Inc.		$ 6,141			$ -			$ -			$ -	
Health Care P/S Contract - Maximus		$ 2,291,959			$ 2,068,372			$ 2,068,372			$ 2,143,223	
Health Care P/S Contract - Ombudsman		$ 226,415			$ 217,000			$ 217,000			$ 230,216	
Health Care P/S Contract - Pacific Health Policy		$ 572,493			$ 587,860			$ 587,860			$ 626,228	
Health Care P/S Contract - MedMetrics		$ -									$ 1,947,259	
Health Care P/S Contract - Delmarva		$ 127,931			$ -			$ -			$ -	
Health Care P/S Contract - UVM VChip		$ -			$ -			$ -			$ -	
Health Care P/S Contract - UVM EQRO		$ 290,276			$ 257,744			$ 257,744			$ 200,000	
Health Care P/S Contract - PSI CSME		$ 1,203,012			$ 564,225			$ 564,225			$ 525,000	
Health Care P/S Contract - PSI MMA		$ -			$ 1,200,000			$ 1,200,000			$ 1,200,000	
Health Care P/S Contract - Atlantic Mkt Research		$ 9,859										
Health Care P/S Contract - Medical Consultant		$ -			$ -			$ -			$ -	
Health Care P/S Contract - Legal Consultant		$ -			$ -			$ -			$ -	
Health Care P/S Contract - Anthem of NH		$ 61,250			$ -			$ -			$ -	
Child Health Outreach Grants		$ -			$ -			$ -			$ -	
Vermont Democracy Fund Grant for PCA		$ -			$ -			$ -			$ -	
Health Care Miscellaneous Expenses		$ 1,234,386			$ -			$ -			$ -	
Health Care P/S Contract - Miscellaneous		$ -			$ 631,051			$ 631,051			$ 889,647	
OVHA Operating Expense/Personnel Services		$ -			$ 5,097,808			$ 5,097,808			$ 7,782,955	
Quality		$ -			$ 5,196,246			$ 5,196,246			$ 3,126,559	
Total Direct Administrative Costs		$ 22,318,060	$ 12.58		$ 27,944,458	$ 15.84		$ 27,944,458	$ 15.86		$ 27,724,990	$ 14.83
Total Program and Administrative Costs	147,847	$ 631,985,934	$ 356.22	147,002	$ 630,985,057	$ 357.70	146,821	$ 639,329,560	$ 362.87	155,768	$ 673,863,427	$ 360.51

Table 10: Comparison of Expenditures for SFY '04 through '07 for Inpatient, Outpatient and Physicians

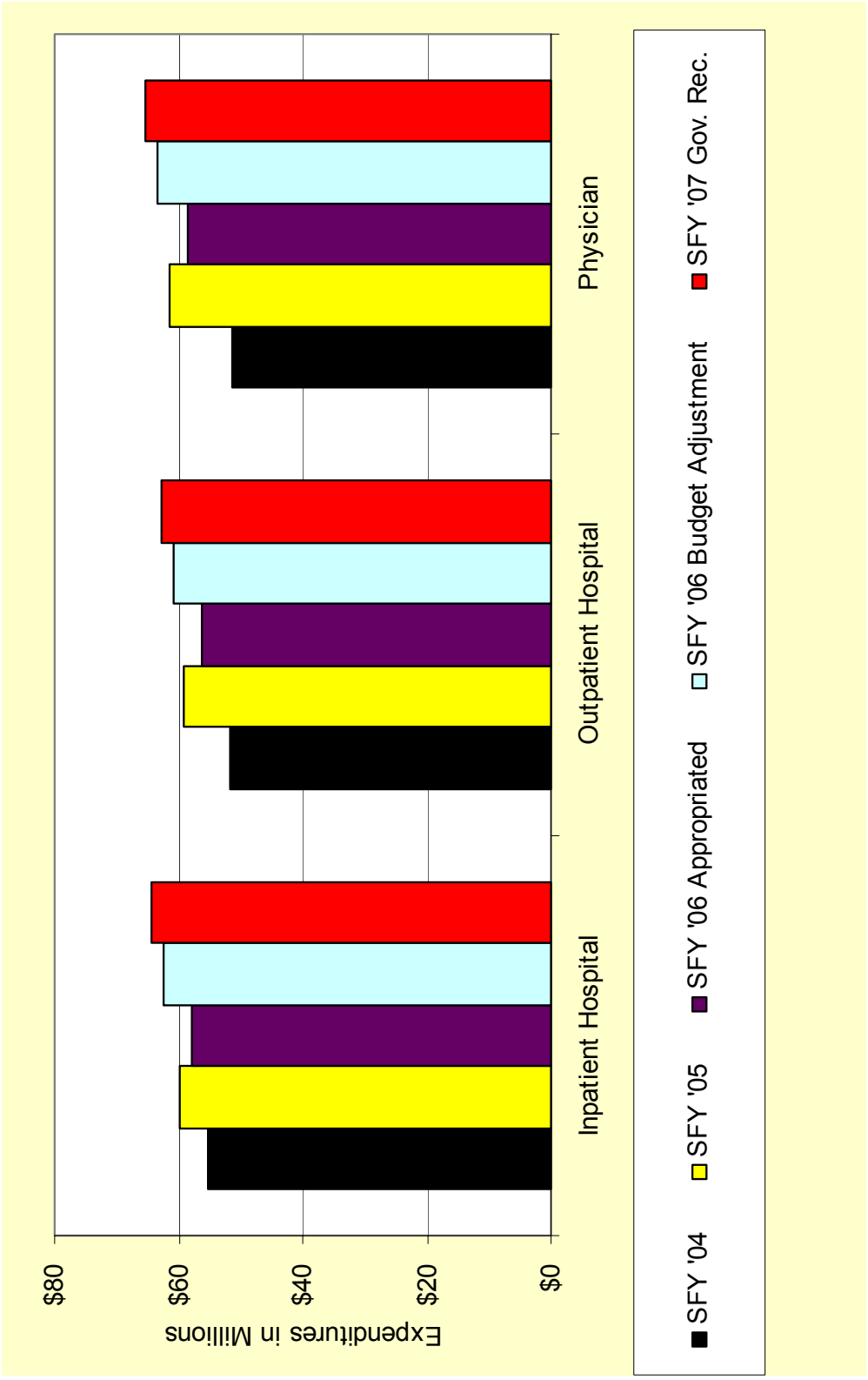


Table 11: Comparison of Inpatient Hospital Expenditures by SFY '04 through '07

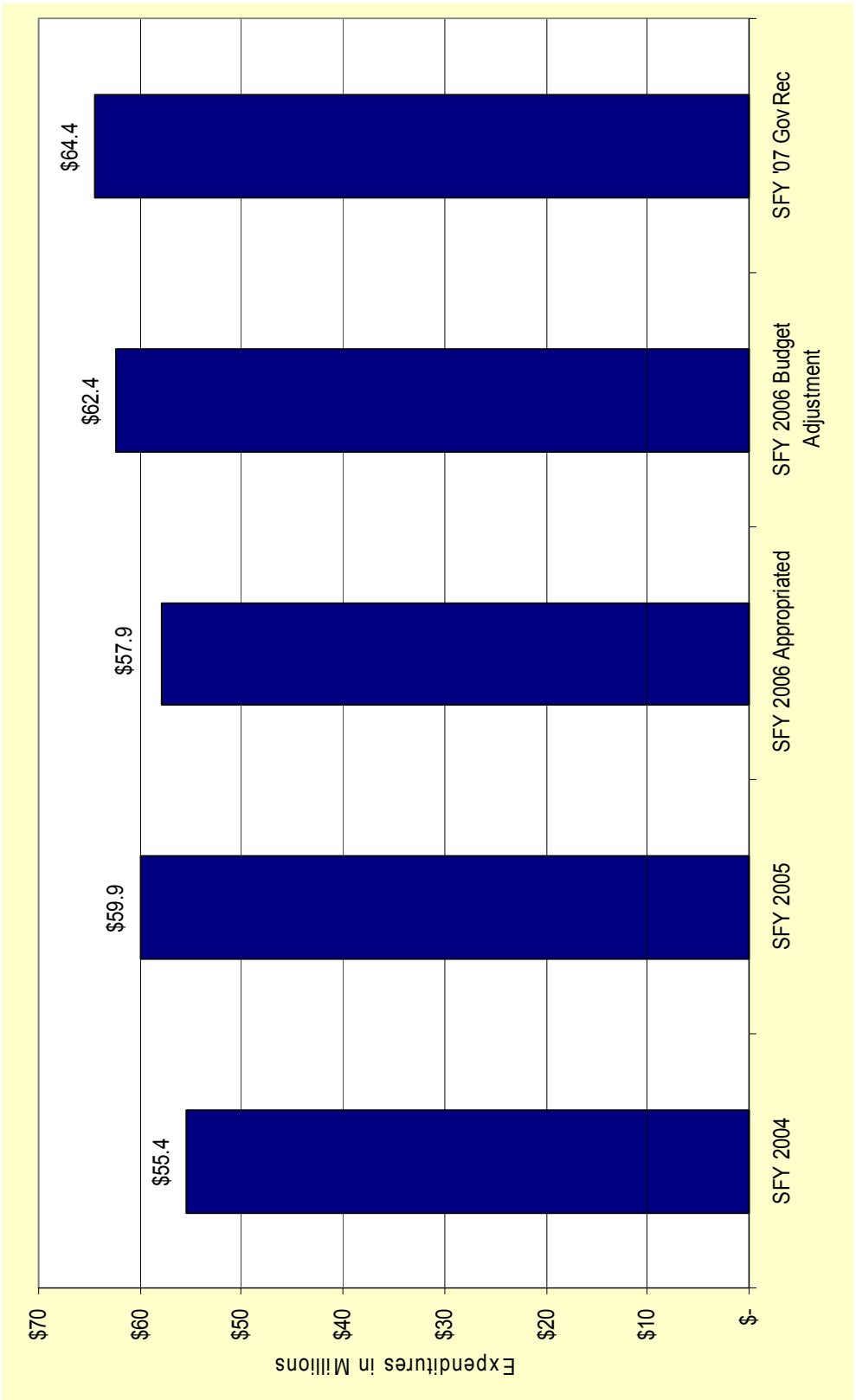


Table 12: Comparison of Outpatient Hospital Expenditures by SFY '04 through '07

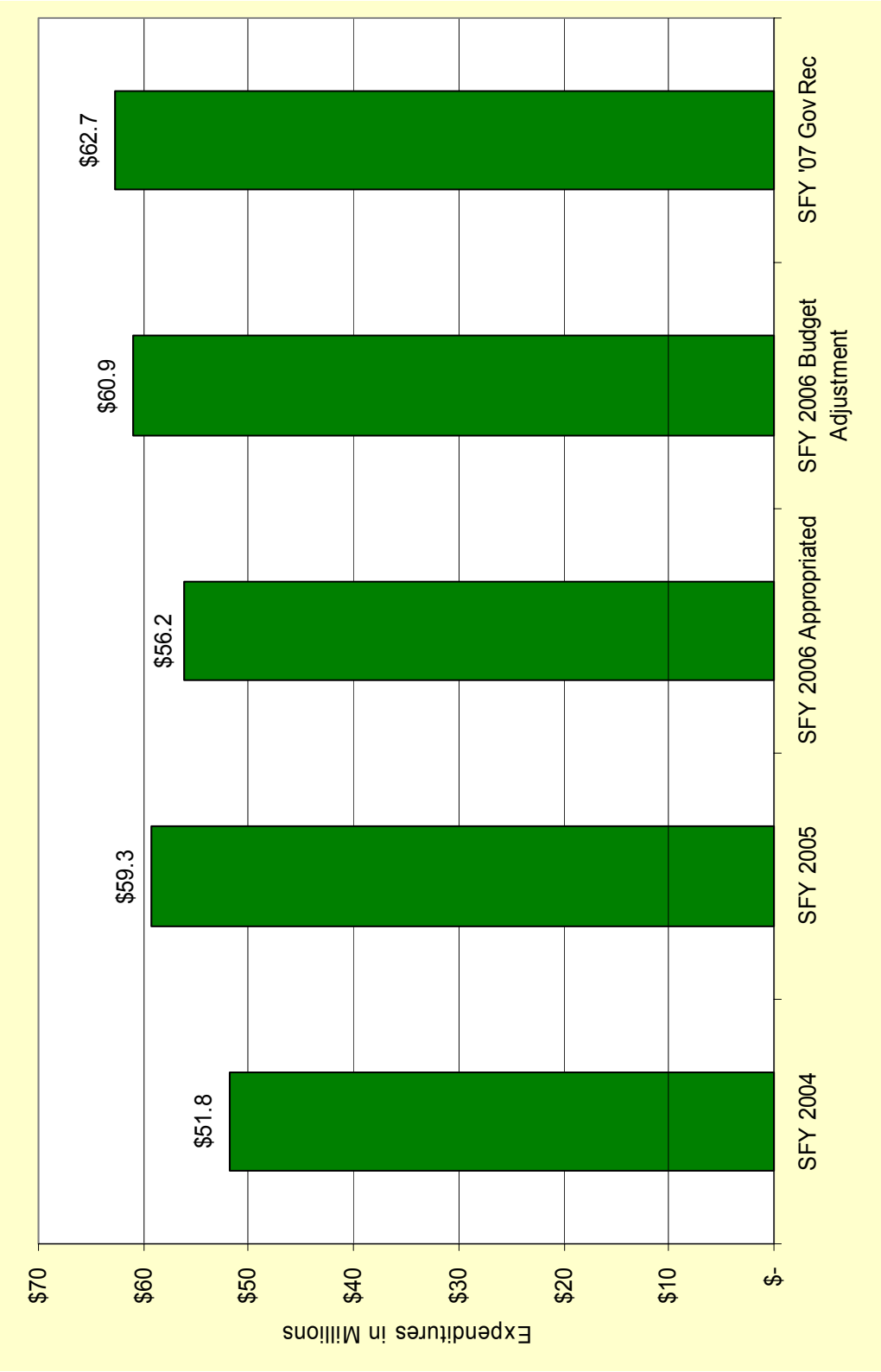


Table 13: Comparison of Physician Expenditures by SFY '04 through '07

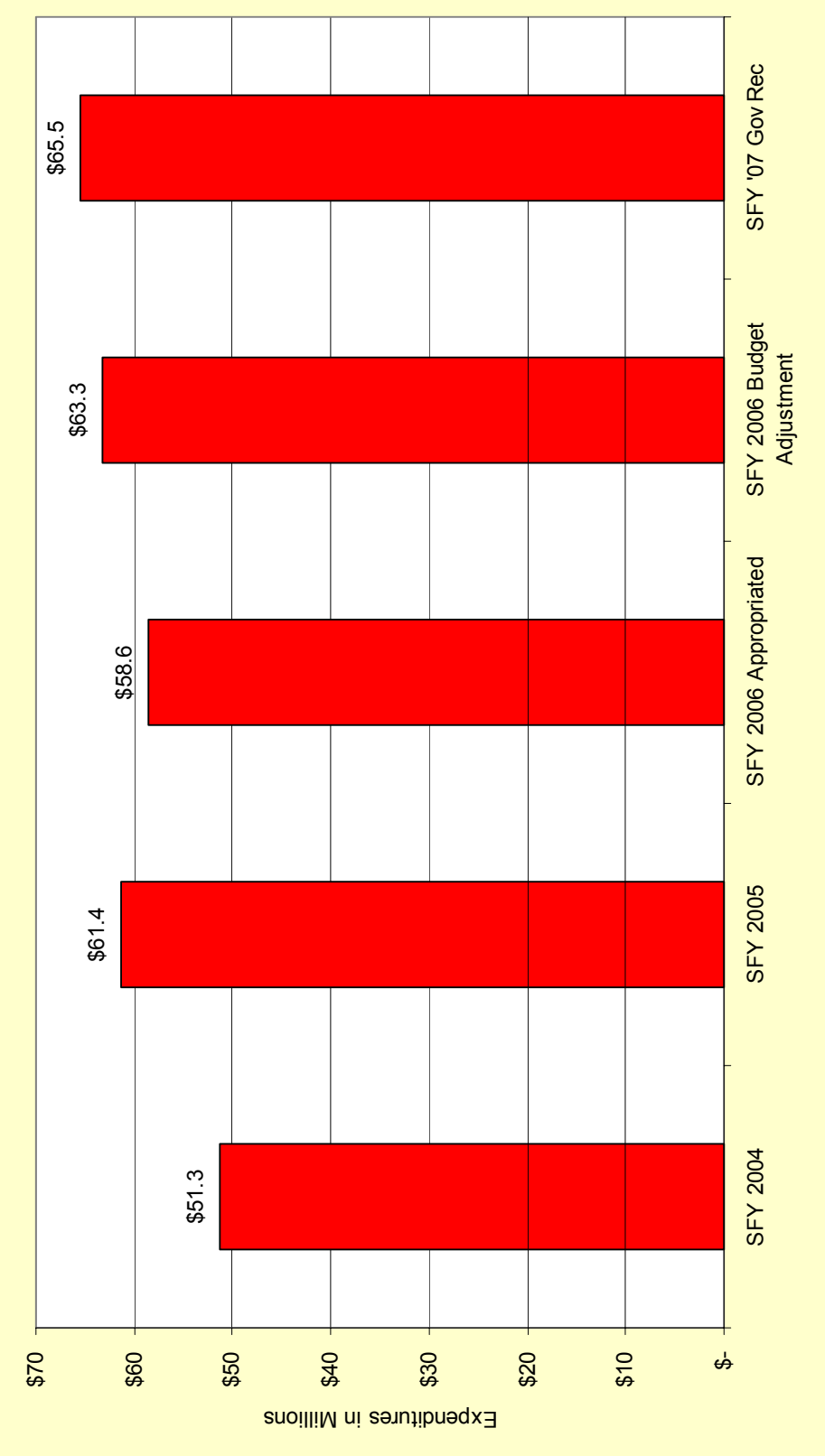


Table 14: Comparison of Expenditures for SFY '04 through '07 for Pharmacy and Long-Term Care Services

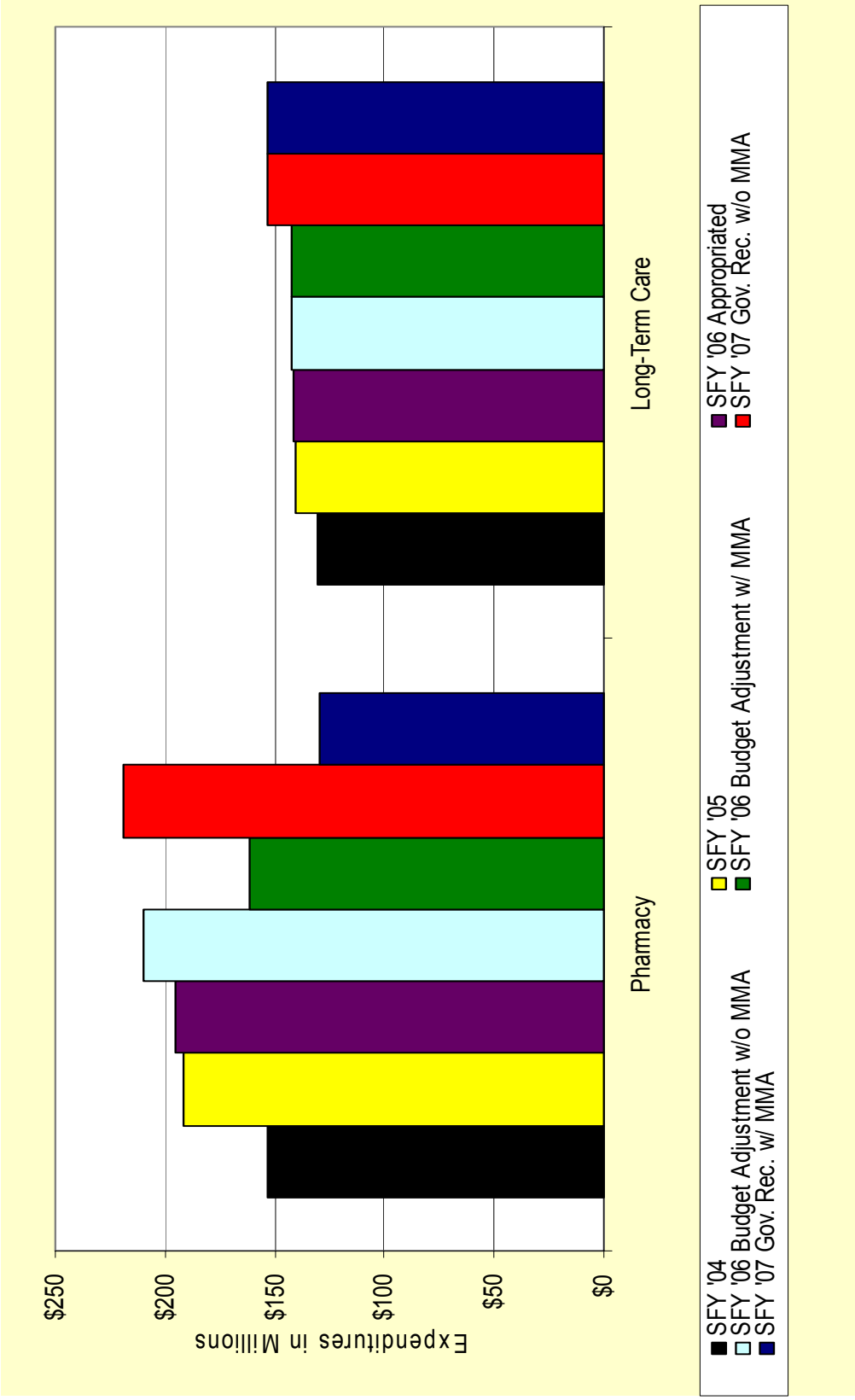


Table 15: Comparison of Pharmacy Expenditures by SFY '04 through '07 Gross Expenditures

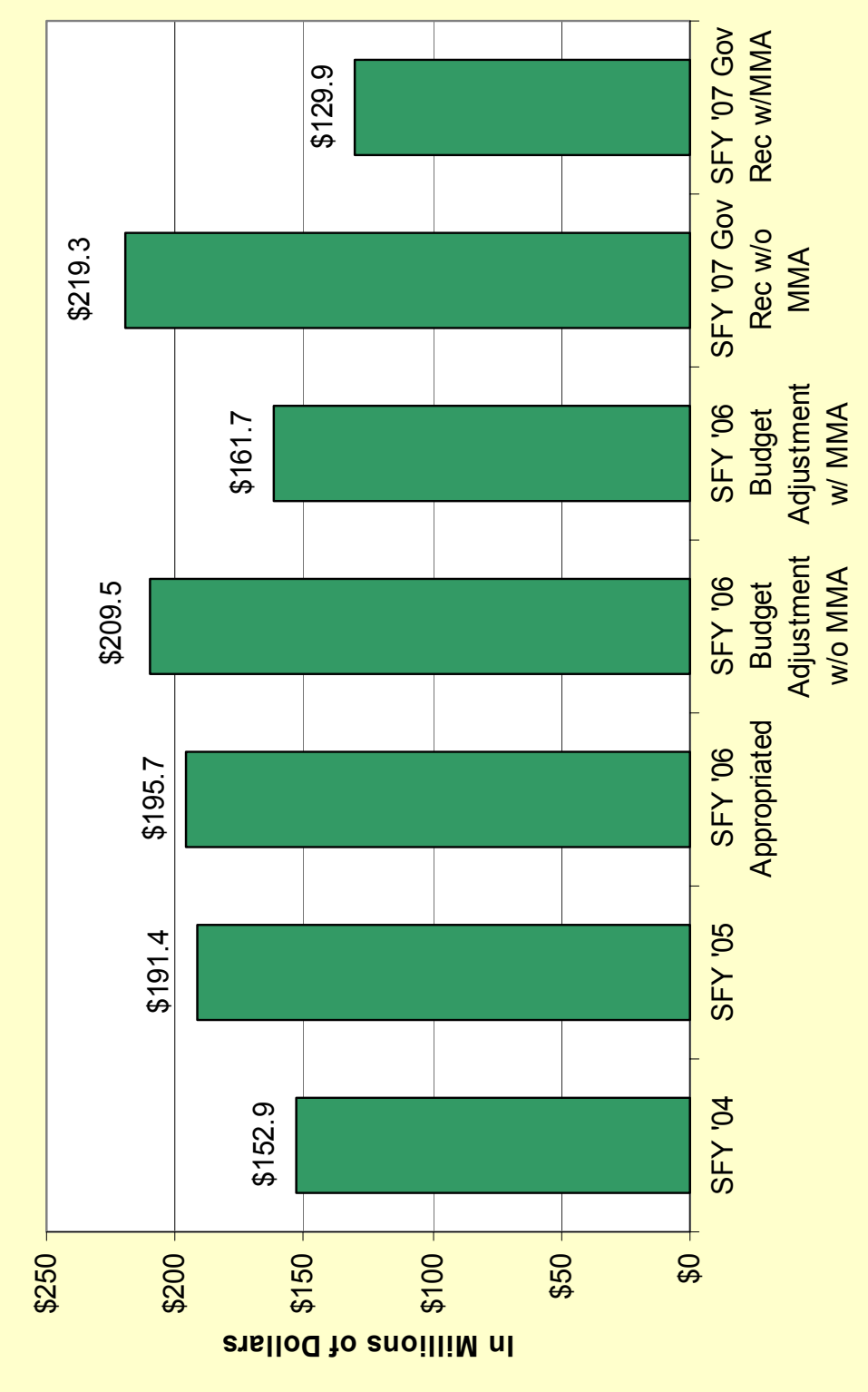


Table 16: Comparison of Pharmacy Expenditures by SFY '04 through '07 Net Expenditures and Rebates/ Supplemental

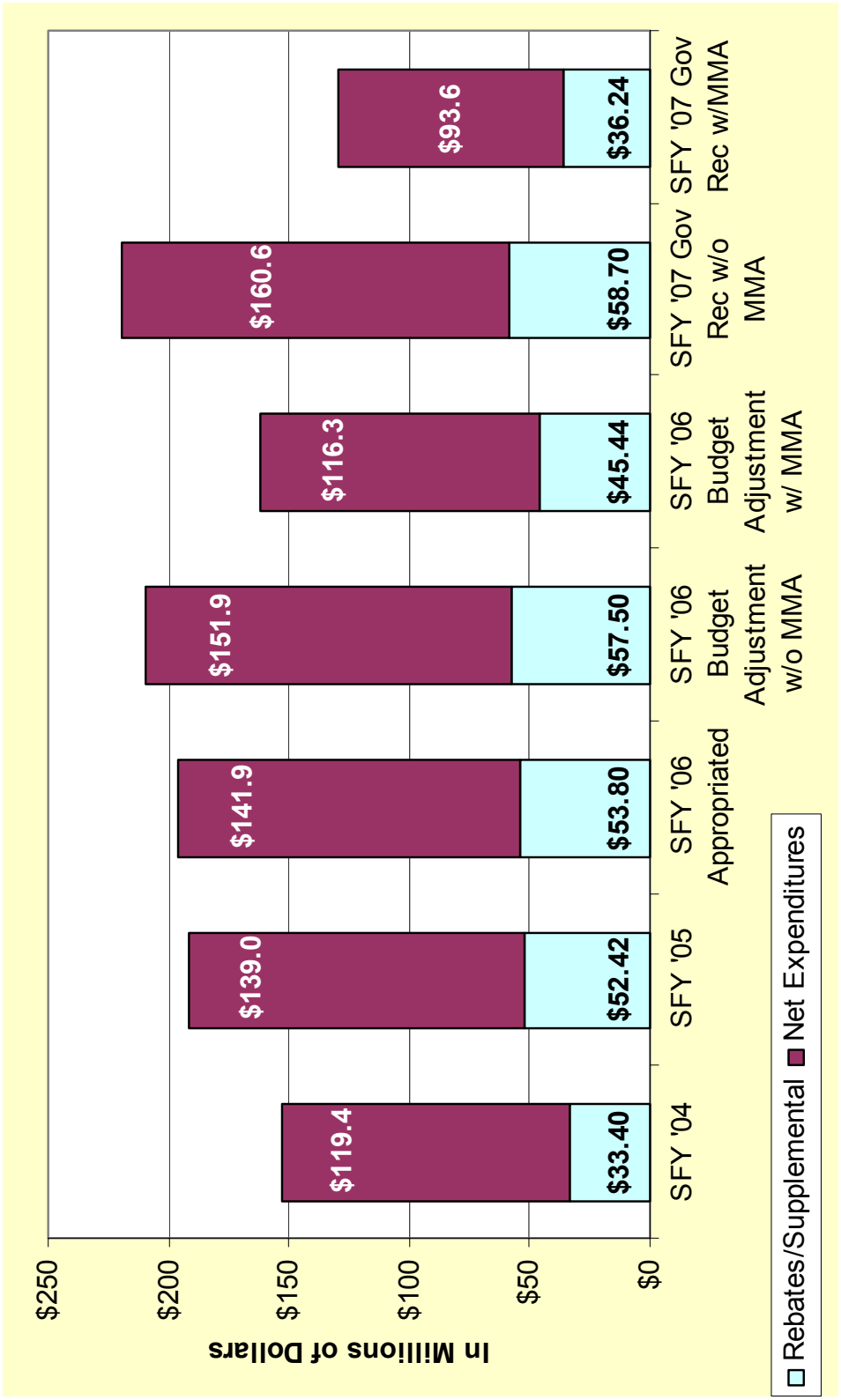
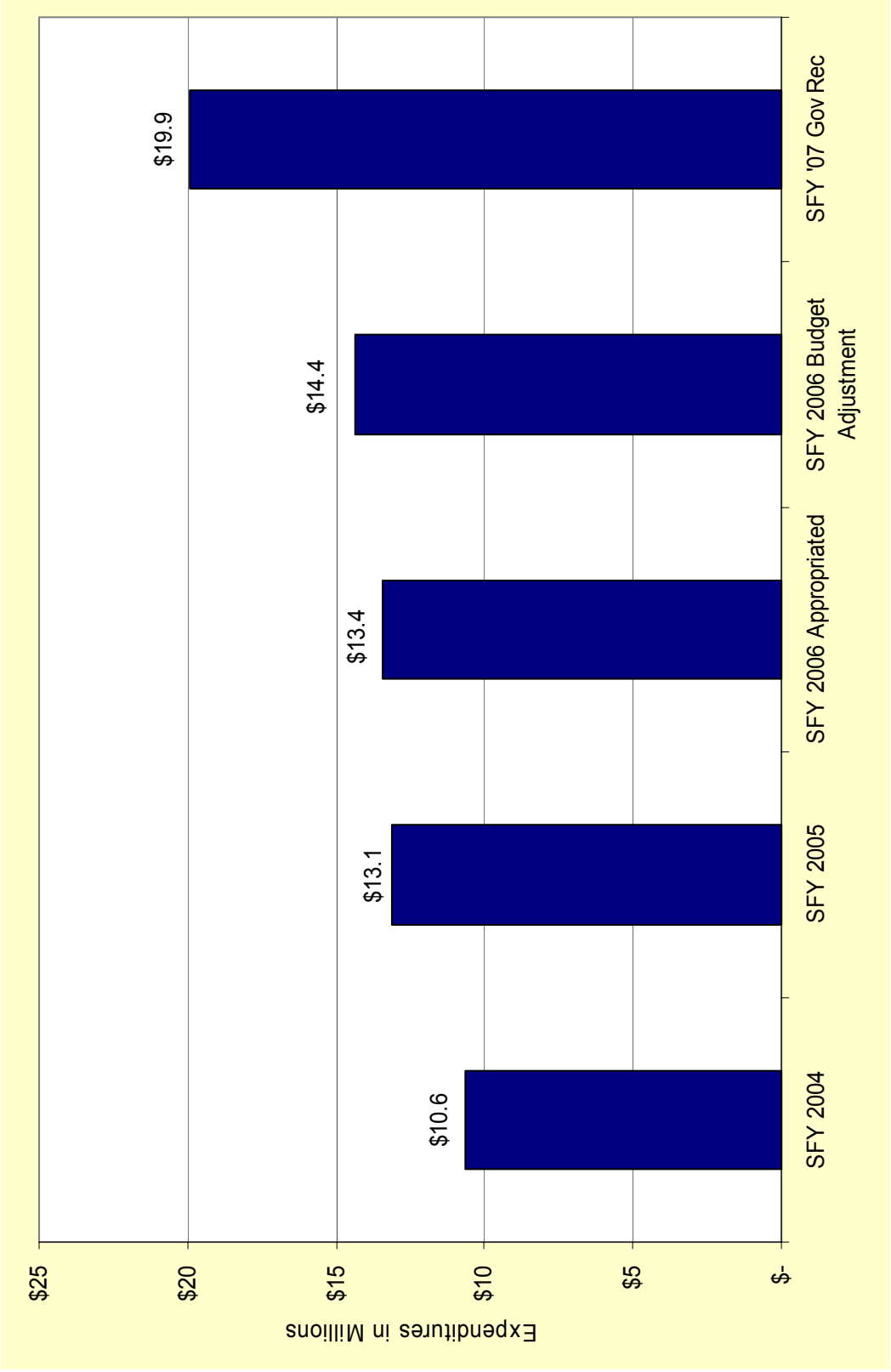


Table 17: Comparison of Personal Care Services Expenditures by SFY '04 through '07



Appendix 1: Acronyms and Abbreviations

AAA	Area Agency on Aging (Triple "A")
AABD	Aid to the Aged, Blind, or Disabled
ABD	Aged, Blind and Disabled
ACCESS	The computer software system for eligibility used by DCF and OVHA to track program information
ADAP	Division of Alcohol and Drug Abuse Programs
AHS	Agency of Human Services
ANFC	Aid to Needy Families with Children (now Reach Up, although ANFC-related Medicaid still exists)
AWP	Average Wholesale Price (AWP -11.9% = Medicaid price)
BCCT	Breast and Cervical Cancer Treatment program
BISHCA	Banking, Insurance, Securities, and Health Care Administration
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services (formerly HCFA)
COB	Coordination of Benefits
CSME	Coverage and Services Management Enhancement
DAIL	Department of Disabilities, Aging and Independent Living
DCF	Department for Children and Families
DME	Durable Medical Equipment
DSH	Disproportionate Share Hospital
DUR	Drug Utilization Review Board
EDS	Electronic Data Systems
EQRO	External Quality Review Organization
ESD	Economic Services Division (of the Department for Children and Families)
ESI	Employer Sponsored Insurance
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FMAP	Federal Medicaid Assistance Participation
FPL	Federal Poverty Level
GA/EA	General Assistance/Emergency Assistance
GCR	Global Clinical Record
HAEU	Health Access Eligibility Unit
HATF	Health Access Trust Fund
HCFA	Health Care Financing Administration (now CMS)
HHA	Home Health Agency
HHS	Health and Human Services
HIFA	Health Insurance Flexibility and Accountability
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
HVP	Healthy Vermonters Program
IGA	Intergovernmental Agreement
LTC	Long-Term Care
MAB	Medicaid Advisory Board
MAC	Maximum Acquisition Cost
MHP	MedMetrics Health Partners (Vermont's pharmacy benefits management contractor)

MMA	Medicare Modernization Act
MMIS	Medicaid Management Information System
MOE	Maintenance of Effort
OVHA	Office of Vermont Health Access
NGA	National Governors Association
PA	Prior Authorization
PACE	Program for All-Inclusive Care for the Elderly
PBA/PBM	Pharmacy Benefits Administrator/Management program
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PC Plus	Primary Care Plus
PDL	Preferred Drug List
PDP	Prescription Drug Plan
PIL	Protected Income Level
PMPM	Per Member Per Month
PNMI	Private Non-Medical Institution
QAPI	Quality Assessment and Performance Improvement
QIAC	Quality Improvement Advisory Council
QDWI	Qualified Disabled Working Individual
QI	Qualified Individual
QMB	Qualified Medicare Beneficiary
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SFY	State Fiscal Year
SLMB	Specified Low-Income Medicare Beneficiary
SSI	Supplemental Security Income
SURS	Surveillance and Utilization Review Subsystem
TPL	Third Party Liability
VDH/DOH	Vermont Department of Health
VHAP	Vermont Health Access Plan
VISION	Vermont's Integrated Solution for Information and Organizational Needs (the statewide accounting system)
VPQHC	Vermont Program for Quality in Health Care

Appendix 2: MCO/Savings – Potential Investment

Description of Programs for MCO Potential Investment - AHS Departments

Department of Disabilities, Aging and Independent Living

Mobility Training and Other Services for the Visually-Impaired Elderly - This program provides specialized independent living services to people over the age of 55. These medically related services include: low vision evaluations; low vision devices; rehabilitation services; orientation and mobility, and Braille instruction.

Developmental Services Respite Funds – This is comparable to the provision of respite and goods under the existing Vermont Medicaid MR/DD waiver respite services.

DS Special Payments for Medical Services Not Covered by XIX - Pays for dental services, adaptive equipment and other ancillary services not covered by Medicaid.

Department For Children and Families

Residential Care for Youth - Residential care for youth in need of intensive behavioral health services.

General Assistance Medical Expenses - The GA medical expenditures include items, services and prescription drugs that are necessary to meet emergency medical needs and specified services and items related to vision and dental needs. An emergency medical need is a need attributable to a medical condition characterized by acute symptoms of sufficient severity that one could reasonably expect the absence of medical attention to result in serious jeopardy to the health of the individual, serious impairment to bodily functions, or serious dysfunction of the bodily organ or part. An emergency medical need for vision is a service or item that aids convalescence from eye surgery, prevents blindness or further deterioration of eyesight, averts risk of physical injury, or allows an individual to continue education or employment. Emergency medical needs for dental services are those necessary to relieve pain, bleeding, or infection. Prescribed drugs are those drugs that are not on the department's list of non-emergency drugs, and fulfill the requirements of the pharmacy best practices and cost control program.

Aid to the Aged, Blind and Disabled - State law specifies that eligible recipients must receive a subsistence amount compatible with decency and "health" as stipulated in 33 VSA §1301. The receipt of state supplement yields categorical eligibility for Medicaid where the majority of the recipients are disabled and have significantly greater health risks than other impoverished groups served by public assistance. The AABD benefit provides an additional resource individuals may use to meet health care needs that are not covered by Medicaid. This amount does not include the amount paid to beneficiaries that is required for states to maintain their eligibility for Medicaid federal matching funds (maintenance of effort - MOE).

Aid to the Aged, Blind and Disabled Assisted Community Care Services – This is the same as Aid to the Aged, Blind and Disabled. Individuals also receive help with personal care and general supervision for physical or mental well-being, including nursing overview and medication management (33 VSA §7101(A)).

Aid to the Aged, Blind and Disabled Residential Care Level III – This is also the same as Aid to the Aged, Blind and Disabled. Individuals receive help with personal care and general supervision for physical or mental well-being, including nursing overview and medication management (33 VSA §7101(A)).

Aid to the Aged, Blind and Disabled Residential Care Level IV - Same as Aid to the Aged, Blind and Disabled. Individuals receive help with personal care and general supervision for physical or mental well-being, including medication management (33 VSA §7101(B)).

Essential Person Program – These are costs associated with providing assistance to a spouse to support the independent living of his or her partner. Individuals must be providing at least one medically necessary service to be eligible for this subpart of the AABD program.

Aid to the Aged, Blind and Disabled Administration – Payments made to Social Security Administration for AABD eligibility determination and benefit delivery.

CUPS - Direct services for parents with children ages 0 to 6 with behavioral health needs not covered by traditional Medicaid, and consultation services to child care providers to address the needs of children with behavioral health issues.

Victims' Medical Services - State funds for victims' medical services not covered by other payers.

Department of Corrections

Intensive Substance Abuse Program (ISAP) - A community-based treatment program intended for offenders whose crimes are non-violent and related to their substance abuse. All programs are approved by, and meet the standards of, the Alcohol & Drug Abuse Programs Division (ADAP) of the Vermont Department of Health. This includes use of the DSM-IV substance use criteria, the American Society of Addiction Medicine's patient placement criterion and approved clinical assessment instruments. Treatment includes an intensive phase (minimum six month, three sessions per week) and an aftercare phase (three months, one session per week). The sessions are led by fully licensed or certified Substance Abuse Counselors and are often co-facilitated by trained DOC staff members who are often credentialed themselves.

Intensive Sexual Abuse Program - This is a community-based treatment program using cognitive-behavioral interventions in a group therapy format to eliminate sexual offending behavior. The program is delivered by mental health professionals under

contract to the Department of Corrections. Supervision by DOC staff is closely coordinated with the treatment that is provided.

Intensive Domestic Violence Program - This community-based program is for men convicted of acts of domestic violence. The program focuses on the elimination of violence and controlling behavior; increasing offender responsibility and empathy. It uses insight-based anger management, cognitive behavioral interventions, and a variety of skill building strategies in order to gain an understanding of their abusive behavior, its impact, and self-change plans.

Women's Health Program (Tapestry) - This program is a six to twelve month residential treatment program that assesses and addresses each woman's overall behavioral, medical and psychiatric needs. Tapestry has a program registered nurse and psychiatric services on-site. The program director is a LICSW, LADC. Of all women admitted to Tapestry, 98% have significant medical and/or mental health problems needing ongoing treatment and monitoring by professional staff.

Community Habilitative Care – This program provides counseling, co-facilitation of treatment programs and case management for offenders in the community who have mental health and/or substance abuse disorders.

Department of Health

AIDS Services - HIV Case Management - These funds provide the infrastructure, specifically AIDS service organization personnel costs, to link persons living with HIV/AIDS to primary care and other related services (e.g., dental care, substance abuse and mental health counseling services).

Tuberculosis (TB) Medical Services - Pursuant to Vermont Statutes found in Title 18, Chapter 21, the TB program provides for the treatment and care of all persons afflicted with TB. As outlined in the statutes, care may include examination of all individuals suspected of TB or individuals in contact with a diagnosed case of active tuberculosis, hospitalization of persons diagnosed with active TB disease, and re-evaluation and re-examination of both individuals diagnosed with active tuberculosis disease and latent TB infection. The treatment and care are funded with state dollars.

Tobacco Cessation - Tobacco is the leading cause of preventable death in Vermont, causing about 800 deaths each year. Treating smoking-related illness in Vermont costs $182 million each year, $56 million of which are Medicaid expenditures. The Health Department's multi-faceted program to reduce the use of tobacco among Vermonters, with special emphasis on discouraging young people from starting to smoke, includes: community-based programs; media and public education programs; surveillance and evaluation activities; and tobacco cessation programs. The tobacco cessation programs include the Vermont QuitLine (1-877-YES-QUIT), a 24-hour toll-free hotline that provides counseling and referrals to those who want to quit; regular community quit smoking classes and individual counseling held throughout the state in each of

Vermont's 14 hospitals; the QuitBucks program providing free or discounted nicotine replacement therapy to all adult smokers; education for dental health providers to improve smoking cessation education and referrals for their patients; and the American Lung Association's Not-On-Tobacco (NOT) teen cessation program in schools.

Family Planning - Family Planning services as funded by state and federal funds support the following clinical services (gender appropriate) – medical history; social history; height; weight; urinalysis; pelvic exam; breast exam; testicular exam; screening and treatment for sexually transmitted diseases; identification, treatment and referral for general health conditions; follow up for reproductive health conditions; provision of and education around appropriate contraceptive methods; information and referral for fertility-related problems; fertility-related counseling; pregnancy testing and counseling; client support and education.

Physican/Dentist Loan Forgiveness - Vermont is the second most rural state in the country with a high proportion of Medicaid eligible, low provider Medicaid payments, and comparatively high provider participation and medical/dental service levels, which could quickly erode without interventions to support that participation. A key to that participation are the funds that encourage providers to come and stay in practice in Vermont. The loan repayment program is an important recruitment and retention program for medical and dental providers to continue to deliver services to low income and underserved populations in Vermont.

Substance Abuse Treatment - Substance abuse treatment includes outpatient, intensive outpatient, residential, detoxification and pharmacological treatment services. The need for these services are determined by a comprehensive clinical assessment done by a licensed substance abuse counselor. In the case of pharmacological treatment, a physician must be involved in determining recommendations for a course of treatment. Diagnosis is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). (Definitions in this manual are also used by mental health professionals.) The clinical assessment determines the diagnosis and the treatment that is medically necessary based on guidelines from the American Society of Addiction Medicine. NOTE: This program is charged to the federal SAPT Block Grant. The Block Grant requires no match but it does mandate some level of state-funded Maintenance of Effort (MOE) and permits the use of the state share of Medicaid funds as the MOE.

Recovery Centers - The Department of Health provides funds that are used to develop and operate recovery centers. This is not done on a fee-for-service basis, as it is for substance abuse treatment. Although recovery services in Vermont are not seen as a medical service, drug and alcohol professionals recognize the importance of these services in supporting treatment services through ongoing social supports and relapse prevention. Research has shown that long-term success of patients is related to having these services in place to support people in their community during and after their episode of treatment.

Emergency Mental Health for Children and Adults - This program includes triage services (available 24 hours per day, seven days a week), assessment, mobile outreach, short-term family stabilization, and referral and screening for hospitalization for children, youth, families and adults experiencing a mental health crisis. In most areas, these services are closely linked to local community hospital emergency departments. In a few areas, hospital diversion programs, community respite beds and crisis respite services are also available.

Respite Services for Youth with Severe Emotional Disturbances and their Families - This service provides relief services for primary caregivers, comparable to existing Vermont Medicaid Waiver respite services.

Mental Health Special Payments for Medical Services - Pays for dental services, eye glasses, adaptive equipment and other ancillary services not covered by Medicaid.

Mental Health Outpatient Services for Adults - This includes mental health assessment, individual and group counseling, case management, medication management, care coordination and outreach supports for adults who have a wide range of problems that are life-disrupting, and sometimes temporarily disabling. Typical characteristics of consumers include: poverty, unemployment, high arrest rates, substance abuse, disabling depression and/or traumatic experiences, and suicidal tendencies.

Mental Health Elder Care - This joint initiative of the Department of Health and the Department of Disabilities, Aging and Independent Living funds mental health staff to work with local communities' elder services network to identify, assess and treat the mental health needs of elders.

Mental Health Consumer Support Programs - These programs provide support for consumer and family organizations, which operate telephone and e-mail support service, assistance and referral, self-help, peer recovery support serrvices, and education about mental illness.

Mental Health CRT Community Services - CRT programs offer a comprehensive range of mental health supports and services for adults with diagnoses of major mental illnesses such as schizophrenia, bipolar disorder, major depression, and certain other serious thought or mood disorders. Approximately 3,200 adults, or 25% of the estimated need, are currently enrolled in CRT.

Mental Health Children's Community Services - Children's Services programs offer a wide array of community-based services and supports, often in collaboration with other state agencies, to assure timely access to effective prevention, early intervention, and behavioral health treatment and supports through a family-centered, multidisciplinary system of care. The programs are designed to serve children and adolescents from birth to eighteen years of age (and, in some cases, until a youth's twenty-second birthday), and their families.

Emergency Medical Services - This program is responsible for standard setting, regulation and planning for statewide emergency medical services systems, training, technical assistance, and program development for local services, and for licensing and certification of all personnel and emergency equipment.

Chronic Disease Epidemiology - This program studies the prevalence and patterns related to chronic diseases not covered by specific federal grants. It develops approaches for prevention, intervention, early detection and treatment of chronic dieases; conducts epidemiologic studies including monitoring, surveillance, and control of chronic diseases and disabling conditions.

Health Research and Statistics - This program handles the collection and analysis of data to determine the health status, morbidity, and mortality of Vermont's population. The data is made available to the public and is used extensively by a variety of health and human service programs at the state and community levels.

Public Health Laboratory - This program covers the non-federal costs of running the public health laboratory, which identifies disease-causing agents in specimens from human, animal, and environmental sources. It identifies the presence of drugs and lead in clinical samples, toxins in environmental samples, and harmful contaminants in drinking water. They test environmental samples for the presence of radiation including radon. They analyzes breath and blood samples for alcohol content and provides technical support to the infrared breath testing programs used by law enforcement officers and courts in the prosecution of drivers accused of being legally intoxicated.

Renal Disease - The renal disease program provides supports for patients undergoing renal dialysis.

Newborn Screening - This program provides lab tests on the blood of virtually every Vermont newborn for early identification of a wide variety of genetic conditions such as PKU.

Blueprint for Health - This is a statewide project to advance innovative solutions and provide support to help doctors and patients effectively manage chronic disease.

Area Health Education Center (AHEC) - This program provides state funds to the statewide network of community and academic partners working together through three AHEC centers and a Program Office to improve the health of Vermonters. Through community-based initiatives, Vermont AHEC works to promote rural health educational opportunities and address health care workforce challenges unique to specific areas of the state.

OVHA

QI1 Eligible Beneficiary Part B Premium - This program provides a state funded payment of the Part B Medicare premium for 1,096 individuals between 100 - 120% of the federal poverty level (FPL) that are above the allotment for federal reimbursement.

VScript Expanded - This program offers pharmacy benefits to low-income seniors and disabled individuals with incomes of 175 - 225% of FPL who are not on Medicare. Individuals on Medicare who were eligible for this program were transferred to the VPharm program (refer to Section 4).

Description of Programs for MCO Investment - Other Departments or Entities

Department of Education

Act 504 - Health Services - School-based assistance to meet the needs of students who have a physical or mental impairment that substantially limits one or more major life activities, but whom do not meet the eligibility criteria for, or choose not to access, special education (which entitles them to an Individualized Education Plan - IEP).

School Nurses - A proportion of health care services provided by school nurses that are not reimbursed by the Early Periodic Screening, Diagnosis and Treatment program (EPSDT).

Health Care Authority

Health System Management - The HCA offers a range of consumer assistance regarding health care. This includes educational publications, lists of carriers and rates, complaint resolution services, and external appeals of denial of benefits. They review insurance policies and proposed health insurance premium rates in the private health insurance market in Vermont. They also oversee a program in consumer protection and quality assurance in managed care plans. In addition, they administer the annual binding budget program for all Vermont hospitals in an effort to monitor and control increases in hospital costs to ensure that licensed health care facilities and services are necessary, non-duplicative and distributed fairly throughout the state. They administer or direct the creation of numerous health care databases to support analyses of Vermont health care expenditures and work with health care professionals in Vermont and regionally to continuously improve the quality of health care throughout the health care system serving all Vermonters.

Vermont State Colleges

Allied Health Education - This program provides state funds to Vermont State Colleges for the training of dental hygienists and licensed practical nurses (LPNs).

University of Vermont

UVM Medical School Grant - This grant provides state funds to the Medical School to train medical professionals.

Veterans' Home

State funds are used to provide medical services not covered by other payers.

State of Vermont - General

Vermont Information Technology Leaders (VITL) - State funds are provided to assist the VITL organization to implement a health information infrastructure for data sharing.

Appendix 3: Federal Poverty Level (FPL) Guidelines – Monthly Household Income

FPL	Household Size							
	1	2	3	4	5	6	7	8
50%	$411	$553	$694	$836	$978	$1,119	$1,261	$1,403
75%	$616	$829	$1,041	$1,254	$1,466	$1,679	$1,891	$2,104
100%	$821	$1,105	$1,388	$1,671	$1,955	$2,238	$2,521	$2,805
150%	$1,232	$1,657	$2,082	$2,507	$2,931	$3,357	$3,782	$4,207
175%	$1,437	$1,933	$2,429	$2,924	$3,420	$3,916	$4,412	$4,908
185%	$1,519	$2,043	$2,567	$3,092	$3,616	$4,140	$4,664	$5,188
200%	$1,642	$2,209	$2,775	$3,342	$3,909	$4,475	$5,042	$5,609
225%	$1,847	$2,485	$3,122	$3,760	$4,397	$5,035	$5,672	$6,310
250%	$2,053	$2,761	$3,469	$4,178	$4,886	$5,594	$6,303	$7,011
300%	$2,463	$3,313	$4,163	$5,013	$5,863	$6,713	$7,563	$8,413
400%	$3,284	$4,417	$5,550	$6,684	$7,817	$8,950	$10,084	$11,217

Note*:* This chart reflects the updated monthly income levels as specified in state rule Bulletin 06-10: 1/1/06 Standards Changes for Health Care. This bulletin is located on the web at: http://www.dsw.state.vt.us/rulechange.htm.

Appendix 4: Medicare Modernization Act (MMA)

Overview

The Medicare Modernization Act (MMA) was signed into law on December 8, 2003. On January 1, 2006, after many months of preparation, the Medicare Part D benefit became available. As of this date, all beneficiaries of Vermont's publicly funded pharmacy programs who are also covered by Medicare should receive their primary pharmacy benefit from Medicare.

Traditional Medicaid *(primarily below 100% of the FPL)*

The pharmacy benefit for those eligible for both Medicare and Medicaid changed.

- The state's coverage is limited to excluded drug classes (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; drugs when used for the anorexia, weight loss, or weight gain) for those who are enrolled in a Part D plan or have creditable coverage.
- No state premium is charged.
- The beneficiary pays the Part D co-pays (from $1 to $5) with the exception that pregnant women and children will have co-pays paid by the state.
- All other cost-sharing is covered by the federal low-income subsidy.
- Drugs that are not on the plan's formulary or are denied by the plan as not medically necessary are not covered without specific approval from OVHA.
- When a Part D plan denies a non-formulary drug or a drug the plan believes is not medically necessary, beneficiaries may apply to OVHA for coverage of the drug after the plan's appeal process is exhausted (through the Independent Review Entity level).
- The prescription drug plans are required to cover all or substantially all of the drugs in the following categories: antidepressant, anticonvulsive, antipsychotic, anticancer, immunosuppresant, and HIV/AIDS.

Vermont's Medicaid Waiver and State Pharmacy Programs *(100% to 225% of the FPL)*

Vermont's VHAP-Pharmacy, VScript, and VScript expanded eligibles who have Medicare were transitioned effective January 1, 2006 to the state's wraparound program, VPharm, where their Medicare supplemental coverage is comparable to their previous coverage from the state.

In December 2005, eligibility rules for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) were changed to eliminate the resource test. This enabled the state to grant eligibility for these programs to beneficiaries of VHAP-Pharmacy whose incomes were below 135 percent of the federal poverty level. By virtue of eligibility for these programs, they became eligible for the full federal low-income subsidy. A study was done, indicating that this change would be at worst cost-neutral for the state, and will likely save money.

VPharm coverage highlights:

- Beneficiaries must be eligible for Part A or enrolled in Part B
- Beneficiaries must be enrolled in a Part D plan and secure the limited income subsidy if it appears they might be eligible.
- Beneficiaries pay premiums to the state of $13, $17 or $35.
- The coverage will be:
    - Payment of cost-sharing that is not covered by the low-income subsidy, including premiums, deductibles, co-payments, coinsurance and the coverage gap (for beneficiaries at the VScript or VScript expanded coverage level of 150% to 225% FPL, only maintenance drugs are eligible for the cost-sharing coverage); and
    - Coverage of drug classes that are excluded from Part D (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; drugs when used for anorexia, weight loss, or weight gain). Some of these may have requirements or limits attached. For beneficiaries at the VScript or VScript Expanded coverage level (150% to 225% FPL), only maintenance drugs in these classes are included in the benefit.
- Drugs that are not on the plan's formulary or are denied by the plan as not medically necessary will not be covered without specific approval from OVHA.
- When a Part D plan denies a non-formulary drug or a drug the plan believes is not medically necessary, beneficiaries may apply to OVHA for coverage of the drug after the plan's appeal process is exhausted (through the Independent Review Entity level).
- The prescription drug plans are required to cover all or substantially all of the drugs in the following categories: antidepressant, anticonvulsive, antipsychotic, anticancer, immunosuppresant, and HIV/AIDS.

Healthy Vermonters Program *(primarily greater than 225% of the FPL)*

Healthy Vermonters beneficiaries who have Medicare may obtain drugs in the Part D excluded classes (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; drugs when used for anorexia, weight loss, or weight gain).

Phased-Down Contribution

The pharmacy benefit under Medicare is conceptually a federal benefit but in the case of dual eligibles; those Medicare beneficiaries who would be eligible for Medicaid, it is funded in the same way as it is funded under Medicaid, with federal and state monies. What in Medicaid is referred to as the state share is called the phased-down state contribution for Medicare. The state contribution design calls for states to annually pay a portion of what they would have paid in Medicaid "state share" in that year for the support of drug coverage of Medicare beneficiaries who are or would be eligible for Medicaid drug coverage. This is the concept sometimes referred to as "clawback". Key concepts of the phased-down contribution include:

- It will be based on Medicaid state expenditures (excluding VHAP-Pharmacy, VScript, and VScript expanded) in calendar year 2003 adjusted for inflation.
- It is calculated on expenditures net of drug rebate.

- States retain a specified portion in support of providing other coverage to their dual eligibles.

Beginning January 1, 2006 states are expected to pay the phased-down state contribution of 90% of the estimated calendar year (CY) state share of Medicaid/Medicare pharmacy expenditures net of rebate. The contribution in future years will be progressively less:

CY 2007	88 1/3%
CY 2008	86 2/3%
CY 2009	85%
CY 2010	83 1/3%
CY 2011	81 2/3%
CY 2012	80%
CY 2013	78 1/3%
CY 2014	76 2/3%
CY 2015 and thereafter	75%

PDP Administration

There are many issues around the administration of existing coverage, including but not limited to providing enrollment and eligibility functionality and data transfers to Medicare; managing our medical coverage for traditional Medicaid eligibles without control of the pharmacy coverage; coordinating any state pharmacy benefits with Medicare pharmacy coverage; and educating/supporting beneficiaries/providers.

PDP Plan Selection

A Medicare-contracted Prescription Drug Plan (PDP) will provide the benefit. Every beneficiary will have a choice of at least two PDPs. Beneficiaries will choose their plans annually. Some beneficiaries have special election periods. For example, dual eligibles may change plans any month.

PDP Drug Coverage

Each Medicare PDP will set the coverage plan (formulary) according to Medicare guidelines.

- The guidelines require mandatory Medicaid class coverage. Coverage does not include specified optional Medicaid coverage including over-the-counter and selected other products (products for the treatment of weight loss/gain, fertility, cosmetic issues, and hair growth; barbiturates; and benzodiazepines).
- Unlike Medicaid, the formulary can be closed; that is, within the Medicare defined classes, not all drugs need to be covered. The regulations specify at least two drugs to a class.
- The formulary may change monthly. That means that beneficiaries who choose a plan based on specific drugs may not be assured the same coverage throughout the year they are enrolled in the plan.

Emergency Transition Plan

During the first part of January the State of Vermont took steps to ensure that Vermonters who were having trouble accessing the federal prescription drug benefit would have state assistance in resolving issues. These steps included:

1) Staffing expanded hours at the state's member services call center, and
2) Staffing both holiday and expanded hours with state employees from the Agency of Human Services to answer provider questions and provide special handling for members in need of assistance in obtaining their prescriptions.

Unfortunately, these steps were not enough. As the billing system failed and the prescription drug plans' toll-free numbers were overwhelmed, Vermonters turned to the state in an attempt to resolve their inability to access their federal benefit. Thousands of Vermonters flooded and overwhelmed the state call center and the emergency lines established within the Agency of Human Services because they could not obtain medically necessary medications through the federal plan.

The state of Vermont acted quickly to pass Vermont House Bill H-592 *An Act relating to Medicare Part D Prescription Drug Benefit and VPharm.* The State legislature appropriated $7 million in state general funds to allow the state to step in and pay as the primary payer for prescription drug claims for both dual eligibles and state pharmacy program eligibles until February 10, 2006 or until the operational problems with Medicare Part D have been resolved.

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2086
www.ovha.state.vt.us

[Phone] 802-879-5900

Agency of Human Services

To: Interested Parties

From: Joshua Slen, Director

Date: January 30, 2006

Re: Medicare Part D Call Volume Handled by Member Services for the Period from January 23-27, 2006

The following table represents the total call volume and the call volume data specific to Medicare Part D, handled by Maximus (member services), for the period from January 23-27, 2006.

	01/23/06 MON	01/24/06 TUE	01/25/06 WED	01/26/06 THU	01/27/06 FRI	WEEKLY SUMMATION
ALL CALLS						
Incoming	1765	1435	1253	1086	1058	6597
Answered	1573	1345	1224	1073	1035	6250
Abandon Percent	11%	6%	2%	1%	2%	
WAIT IN MINUTES						
Average	2.32	1.15	0.45	0.18	0.25	
Maximum	8.98	7.22	4.87	3.17	3.82	
AVERAGE CALL LENGTH IN MINUTES						
	3.60	3.55	3.63	3.70	3.73	
PERCENT ANSWERED						
in 2 Mins	51%	78%	95%	99%	98%	
in 4 Mins	79%	91%	99%	100%	100%	
CALL COUNTS: VPHARM & DUALS						
TOTAL	401	343	309	241	233	1527
PERCENT OF ALL CALLS	25%	26%	25%	22%	23%	24%

HIGHLIGHT:
Call volume specific to Medicare Part D reduced from a high of 850 calls on January 5, 2006 to a low of 233 on January 27, 2006.

REFERENCE:
For historical data reference the memos to Interested Parties, from Joshua Slen, regarding:
Medicare Part D Call Volume Handled by Member Services for the Period from January 3-7, 2006
Medicare Part D Call Volume Handled by Member Services for the Period from January 9-13, 2006
Medicare Part D Call Volume Handled by Member Services for the Period from January 16-20, 2006

VERMONT

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312 Hurricane Lane, Suite 201
Williston, VT 05495-2086
www.ovha.state.vt.us

[Phone] 802-879-5900

Agency of Human Services

To: Interested Parties

From: Joshua Slen, Director

Date: January 30, 2006

Re: Medicare Part D Implementation Update with Claim Volume and Associated Expenditures for the Period from January 1-26, 2006

The Office of Vermont Health Access (OVHA) has been engaged in numerous activities to resolve Medicare Part D implementation issues:

- Communicating with the Centers for Medicare and Medicaid Services (CMS), other states and other entities (e.g., Vermont's Congressional Delegation) to clarify reimbursement details and to receive performance data (metrics) to support Federal claims that the system is operating appropriately.
- Informing CMS that the State of Vermont will require information two weeks in advance of "flipping the switch" because it isn't feasible to provide responsible communication to providers and beneficiaries in a shorter time frame.
- Communicating with Vermont's Congressional Delegation to reinforce the role and importance of the federal bill (i.e., The Requiring Emergency Pharmaceutical Access for Individual Relief, or REPAIR Act), that provides federal reimbursement for states, pharmacies, and beneficiaries for out-of-pocket costs attributable to Medicare Part D.
- Drafting a transition/contingency plan and coordinating activities which support that plan.
- Drafting language for a public service announcement (PSA) and press releases to provide beneficiaries with Medicare Part D information and resources.
- Drafting a letter to CMS requesting an extension of federal reimbursement from February 15, 2006 to at least the end of February.

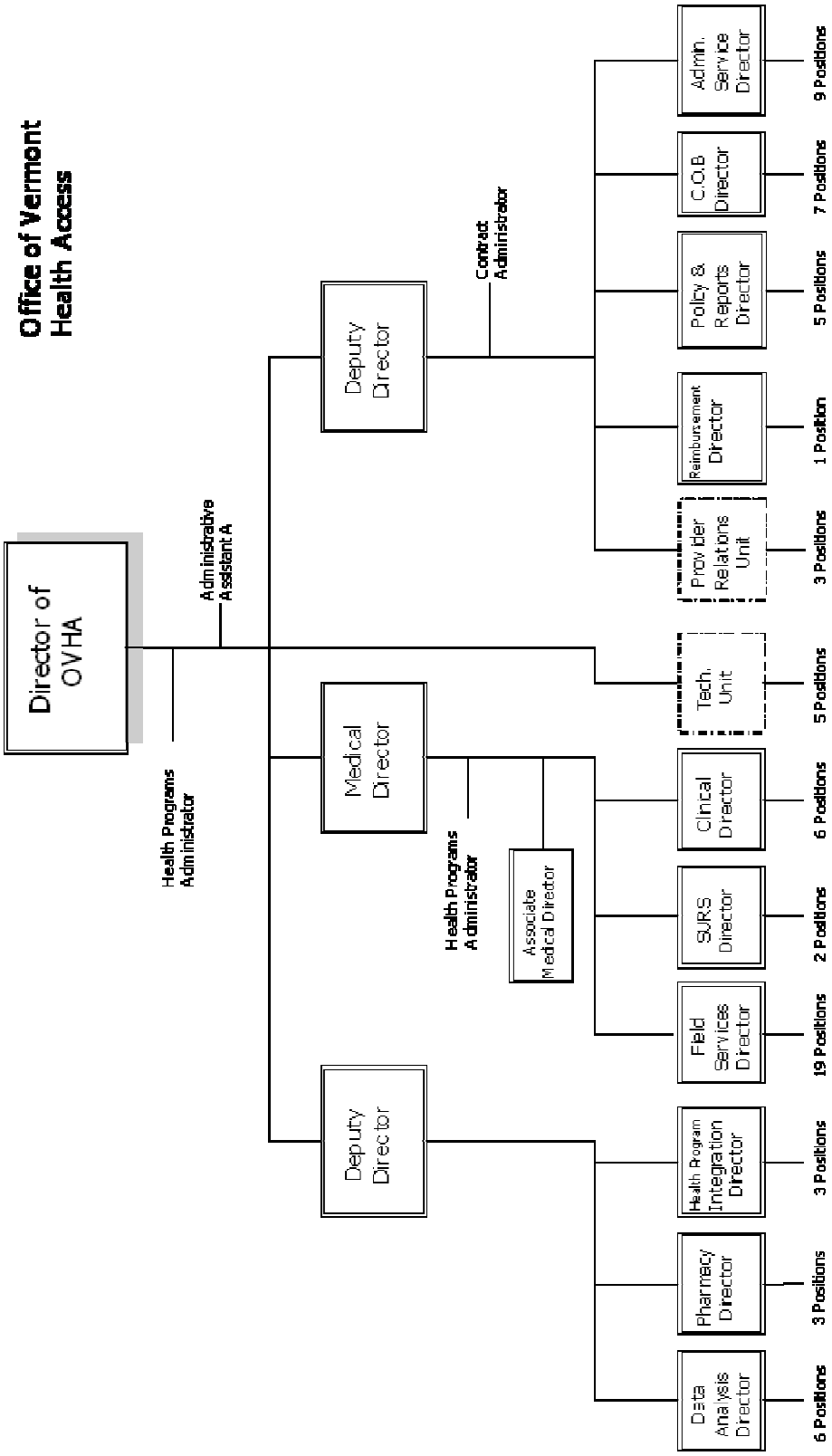
During the week, the OVHA paid just over $80,000 in premiums to the Prescription Drug Plans (PDP) for approximately 13,000 people.

The OVHA continues to process claims and expend state-only funds to ensure that duals receive their prescription medications. The claim volume (with associated expenditures incurred by the State of Vermont) is included in the following table.

Medicare Part D Data	
For the Period from 01/01/06 – 01/05/06	
Claim Volume	
Daily Average	Total
424	2,121
Expenditures	
Daily Average	Total
$17,868	$89,342
For the Period from 01/06/06 – 01/12/06	
Claim Volume	
Daily Average	Total
3,692	25,841
Expenditures	
Daily Average	Total
$222,820	$1,599,738
For the Period from 01/13/06 – 01/19/06	
Claim Volume	
Daily Average	Total
2,879	20,159
Expenditures	
Daily Average	Total
$160,267	$1,121,869
For the Period from 01/20/06 – 01/26/06	
Claim Volume	
Daily Average	Total
3,292	23,044
Expenditures	
Daily Average	Total
$187,798	$1,314,586
Grand Total*	
Claim Volume: 71,245	
Expenditures: $4,033,114**	

*Weekly totals do not reconcile to the Grant Total due to the claims adjudication process.
**The OVHA has incurred additional expenditures (e.g., contractor costs) exclusive of claims.

Appendix 5: Organization Chart



Appendix 6: Federal Match Rates Chart

FEDERAL MATCH RATES

Title XIX / Medicaid (program) & Title IV-E / Foster Care (program):

Federal Fiscal Year					State Fiscal Year				
FFY	From	To	Federal Share	State Share	SFY	From	To	Federal Share	State Share
1995	10/01/94	09/30/95	60.82%	39.18%	1995	07/01/94	06/30/95	60.50%	39.50%
1996	10/01/95	09/30/96	60.87%	39.13%	1996	07/01/95	06/30/96	60.86%	39.14%
1997	10/01/96	09/30/97	61.05%	38.95%	1997	07/01/96	06/30/97	61.01%	38.99%
1998	10/01/97	09/30/98	62.18%	37.82%	1998	07/01/97	06/30/98	61.90%	38.10%
1999	10/01/98	09/30/99	61.97%	38.03%	1999	07/01/98	06/30/99	62.02%	37.98%
2000	10/01/99	09/30/00	62.24%	37.76%	2000	07/01/99	06/30/00	62.17%	37.83%
2001	10/01/00	09/30/01	62.40%	37.60%	2001	07/01/00	06/30/01	62.36%	37.64%
2002	10/01/01	09/30/02	63.06%	36.94%	2002	07/01/01	06/30/02	62.90%	37.10%
2003	10/01/02	09/30/03	62.41%	37.59%	2003	07/01/02	06/30/03	62.57%	37.43%
fiscal relief	**04/01/03**	**09/30/03**	**66.01%**	**33.99%**			**fiscal relief - Title XIX only:**	63.47%	36.53%
Per TRRA...applies only to Title XIX (excluding DSH pymts)								**no adj for DSH**	
2004	10/01/03	09/30/04	61.34%	38.66%	2004	07/01/03	06/30/04	61.61%	38.39%
fiscal relief	**10/01/03**	**06/30/04**	**65.36%**	**34.64%**			**fiscal relief - Title XIX only:**	65.52%	34.48%
Per TRRA...applies only to Title XIX (excluding DSH pymts)								**no adj for DSH**	
2005	10/01/04	09/30/05	60.11%	39.89%	2005	07/01/04	06/30/05	60.42%	39.58%
2006	10/01/05	09/30/06	58.49%	41.51%	2006	07/01/05	06/30/06	58.90%	41.10%
2007	10/01/06	09/30/07	58.93%	41.07%	2007	07/01/06	06/30/07	58.82%	41.18%
2008	10/01/07	09/30/08	58.57%	41.43%	2008	07/01/07	06/30/08	58.66%	41.34%

Title IV-D / OCSE Admin:

FFY	From	To	Regular	Enhanced	FFY	From	To	Regular	Enhanced
1975-81	07/01/75	09/30/81	75.00%	N/A	1996	10/01/95	09/30/96	66.00%	90.00%
1982	10/01/81	09/30/82	75.00%	90.00%	1997	10/01/96	09/30/97	66.00%	90.00%
1983-85	10/01/82	09/30/85	70.00%	90.00%	1998	10/01/97	09/30/98	66.00%	90.00%
1986	10/01/85	09/30/86	66.65%	85.69%	1999	10/01/98	09/30/99	66.00%	80.00%
1987	10/01/86	09/30/87	70.00%	90.00%	2000	10/01/99	09/30/00	66.00%	80.00%
1988-89	10/01/87	09/30/89	68.00%	90.00%	2001	10/01/00	09/30/01	66.00%	80.00%
1990	10/01/89	09/30/90	64.85%	88.43%	2002	10/01/01	09/30/02	66.00%	80.00%
1991	10/01/90	09/30/91	66.00%	90.00%	2003	10/01/02	09/30/03	66.00%	80.00%
1992	10/01/91	09/30/92	66.00%	90.00%	2004	10/01/03	09/30/04	66.00%	N/A
1993	10/01/92	09/30/93	66.00%	90.00%	2005	10/01/04	09/30/05	66.00%	N/A
1994	10/01/93	09/30/94	66.00%	90.00%	2006	10/01/05	09/30/06	66.00%	N/A
1995	10/01/94	09/30/95	66.00%	90.00%	2007	10/01/05	09/30/06	66.00%	N/A
					Note: IV-D Expenses for Paternity Testing are reimbursed @ 90% ffp				

Title XXI / SCHIP (program & admin):

Federal Fiscal Year					State Fiscal Year				
FFY	From	To	Federal Share	State Share	SFY	From	To	Federal Share	State Share
1999	10/01/98	09/30/99	73.38%	26.62%	1999	07/01/98	06/30/99	73.38%	26.62%
2000	10/01/99	09/30/00	73.57%	26.43%	2000	07/01/99	06/30/00	73.52%	26.48%
2001	10/01/00	09/30/01	73.68%	26.32%	2001	07/01/00	06/30/01	73.65%	26.35%
2002	10/01/01	09/30/02	74.14%	25.86%	2002	07/01/01	06/30/02	74.03%	25.97%
2003	10/01/02	09/30/03	73.69%	26.31%	2003	07/01/02	06/30/03	73.80%	26.20%
2004	10/01/03	09/30/04	72.94%	27.06%	2004	07/01/03	06/30/04	73.13%	26.87%
2005	10/01/04	09/30/05	72.08%	27.92%	2005	07/01/04	06/30/05	72.30%	27.71%
2006	10/01/05	09/30/06	70.94%	29.06%	2006	07/01/05	06/30/06	71.17%	28.83%
2007	10/01/06	09/30/07	71.25%	28.75%	2007	07/01/06	06/30/07	71.17%	28.83%

Appendix 7: The Capitated Program for Opiate Dependency

Overview

Opiate addiction is a serious and growing problem in Vermont. For the four most recent years that data is available, heroin and other opiates are the only drugs for which there is a consistent increase in reported abuse each consecutive year (ADAP-VDH. 2001 Treatment Admissions Data Report). Opiate-seeking behavior costs the health care system millions in office and Emergency Department visits, expensive work-ups for pain complaints, and the cost of prescriptions that are inevitably given by health care providers struggling to distinguish drug seeking from true chronic pain. As this problem grows and affects increasingly diverse segments of the community, primary care providers need to be able to have a role in the diagnosis and treatment of a condition that could afflict any one of their patients. The arrival of buprenorphine allows this and represents the first major innovation in the treatment of opiate dependency in over 40 years.

OVHA has decided that the most promising approach to increasing buprenorphine treatment capacity in Vermont is to target primary care physicians and practices. Indeed, the most revolutionary aspects of buprenorphine include that its use is well within the primary care scope of practice, and that it is not marginalized by the need for heavy regulation. Buprenorphine has been shown to work extremely well for those who may represent an active presence in primary care practices already, those whose addiction is of shorter duration, or those who abuse narcotic pain medicines and frequent primary care sites with drug-seeking behavior.

OVHA seeks to encourage primary care physicians to provide buprenorphine treatment by prepaying an enhanced capitated rate with an additional bonus based on participation rate. The enhancement would be predicated upon providers following a “Best Practices” protocol as established by the Division of Alcohol and Drug Abuse Programs (ADAP) - VDH and subject to review via Medicaid claims data as well as office-based chart review. Participating practices would allow OVHA and ADAP to assist them in establishing microsystems, protocols and educational opportunities for the staff as well as helping the providers achieve more readily “Best Practices” status.

The capitated rate would be based on two separate factors: the complexity of the patients a provider may be treating; and second, the absolute number of patients any provider is treating.

Patient Complexity would be assessed consistent with Vermont’s Practice Guidelines and would be classified as those requiring induction, stabilization or maintenance. Using approximate numbers of visits that “Best Practices” would mandate for each of these levels, a capitated reimbursement figure can be derived. For example: a patient in Complexity Level I (maintenance) might only require one or two office visits per month at the 10-15 minute rate whereas a Complexity Level III (induction) patient could

well need three to five office visits the first week followed by the following using current Medicaid reimbursement numbers per month:

I. Maintenance only	99213 OV	(2) visits	$ 67.52
II. Stabilization	99213 OV	(6-8) visits	$202.56 - $270.00
III. Induction	99205 OV	(1) visit	$ 78.89
	99213 OV	(11) visits	$371.36 - $350.00

A bonus of 5% could be added for every multiple of five in the number of patients a provider has under his/her care. Thus a physician treating eight Level I patients would receive $594.17 per month (8 x $67.52 = $540.16 + (0.10 x 540.16)) whether those patients required more or less office visits than anticipated.

OVHA intends to utilize a number of benchmarks in order to assess the program's success in increasing access to buprenorphine treatment for Medicaid beneficiaries.

Legislative Report

Sec. 300. CAPITATED PROGRAM FOR TREATMENT OF OPIATE DEPENDENCY

(a) As part of the development of the Office of Vermont Health Access's care coordination initiative, there shall be developed a capitated program for the treatment of opiate dependency. In cooperation with all commercial insurers present in Vermont, the Department of Corrections, the Office of Drug and Alcohol Abuse Programs, the Office of Vermont Health Access shall:

(1) develop a state-wide electronic registry and treatment service assessment of patients with opiate dependency;

(2) develop a state-wide, integrated protocol for the treatment of opiate dependency;

(3) identify the administrative and financial resources necessary to successfully implement and maintain the capitated program for the treatment of opiate dependency;

(4) use a capitated payment methodology and set payment rates; and

(5) create a plan to measure program outcomes with specific benchmarks.

(b) The office shall provide a preliminary report and a recommendation for ongoing funding to the House and Senate committees on appropriations, the House human services committee, and the Senate health and welfare committee no later than January 15, 2006.

Introduction

Opiate addiction is a serious and growing problem in Vermont. For the four most recent years that data is available, heroin and other opiates are the only drugs for which there is a consistent increase in reported abuse each consecutive year[2]. The number of heroin users seeking treatment jumped from 800 to over 1000 in 2003 and has remained over 1000 per year each year since[3]. Treatment programs have been operating at capacity and addicts seeking help wait on lists for a program slot. There is no other chronic, debilitating medical condition for which this is the case. Meanwhile, opiate-seeking behavior costs the health care system millions in office and Emergency Department visits, expensive work-ups for pain complaints, and the cost of prescriptions that are inevitably given by health care providers struggling to distinguish drug seeking from true chronic pain.

Prior to FDA approval of buprenorphine for office-based treatment, the only option available for medication assisted treatment was an Opiate Treatment Program (OTP) that was licensed to dispense methadone and LAAM (subsequently removed from the market due to cardiac problems). This remains a critical and necessary option for those with long-standing opiate addiction. However, the two OTPs that are licensed in

[2] ADAP-VDH. 2001 Treatment Admissions Data Report.
[3] Cimaglio, B. PowerPoint presentation, 2005.

Vermont do not remotely have the capacity to treat all opiate addicted individuals. The stigma associated with treatment at a "methadone clinic" and geographic distances limit the ability of OTPs to meet the treatment needs of Vermont communities. The high-degree of regulation of OTPs has meant that treatment of opiate addiction has remained far outside of the mainstream of medical practice. As this problem grows and affects increasingly diverse segments of the community, primary care providers need to be able to have a role in the diagnosis and treatment of a condition that could afflict any one of their patients. The arrival of buprenorphine allows this and represents the first major innovation in the treatment of opiate dependency in over 40 years.

Buprenorphine was FDA approved for office-based treatment in 2002. Several studies have shown that it is as effective as methadone in reducing illicit opioid use. Its safety and efficacy for use in office-based settings has been well documented[4]. The most commonly prescribed form of buprenorphine is Suboxone. Suboxone is buprenorphine combined with naloxone, an opiate antagonist that can produce unpleasant side effects if the tablets are crushed for intravenous injection. This is critical to decreasing the street value of the medication and making it safer for the less-regulated environment of office-based treatment.

Between the years 2004 and 2006 there has been an increase of Vermont physicians who have obtained buprenorphine waivers from 68 to more than 105. The majority of these providers are primary care specialists. There are 80 current Medicaid prescribers, and approximately 495 Medicaid beneficiaries who are in active buprenorphine treatment with one of these doctors. However, Vermont statistics from the 2002-2003 National Surveys on Drug Use and Health indicate there may be over 20,000 Vermonters over the age of twelve who are in need of treatment due to illicit drugs. It is clear that something needs to be done in order to increase access to this effective, evidence-based treatment. The challenge involves understanding the barriers that primary care physicians face in the provision of this treatment, and determining what sort of incentives and office system supports might facilitate increased access for Medicaid beneficiaries.

Work to Date

Outreach/Partners

OVHA's primary partner in this effort is the Division of Alcohol and Drug Abuse Programs (ADAP) at the Vermont Department of Health. OVHA's program seeks to increase access to buprenorphine treatment through the mechanisms available to an insurer. Assuring that this occurs within the context of best clinical practice is the focus and expertise that ADAP brings to the collaboration. To that end, OVHA's Medical Director and Quality Improvement Coordinator are working closely with Todd Mandell, MD, ADAP Medical Director. Ongoing conversations involve ADAP leadership, including Barbara Cimaglio, Deputy Commissioner and Peter Lee, Chief of Treatment.

[4] SAMHSA. TIP 40, p. 18-19.

The Medical Director has consulted with the Medical Directors of the commercial plans, including Elizabeth Schneider, MD of MVP, Robert Hockmuth, MD of Cigna and Stephen Perkins, MD of Blue Cross / Blue Shield of Vermont. All of the commercial plans include buprenorphine treatment in benefits packages, but none is currently addressing the primary care provider shortage through a program such as the one OVHA is planning to implement. Cigna manages access to buprenorphine through pharmacy prior authorization, but the only criterion is that the prescriber be certified through the legally required specialist credentials or buprenorphine training. MVP's benefit is much more restrictive. Requirements include having had inpatient treatment, willingness to participate in an outpatient program, "high-risk for relapse" and ability to "be abstinent from other mood altering substances". Coordinating efforts is a challenge with this degree of variation, but remains a long-term goal.

The addictions treatment community and beneficiaries have been approached through the Central Vermont Substance Abuse Services Advisory Board and the Vermont Harm Reduction Coalition. Primary care doctors have been consulted in Bennington, Caledonia, Chittenden, Washington and Windham counties.

The Department of Corrections is another crucial partner in the current effort. It is estimated that up to 80% of inmates nationwide have a substance abuse problem. 80% of Vermont inmates are non-violent offenders[5], many with convictions directly or indirectly related to illicit drugs. A great deal of the recidivism seen in the incarcerated population is related to the persistent consequences of drug addiction. When Vermont inmates are released, 98% become Medicaid eligible. Enhancing the availability of effective treatment options for this population has the potential to significantly impact the social and financial costs inherent in crime and incarceration. Susan Wehry, MD, Medical Director at DOC, has been working with OVHA from this perspective.

Research

Research has involved a review of the literature on buprenorphine efficacy and appropriateness for office-based treatment. It has included the Vermont buprenorphine practice guidelines and the Treatment Improvement Protocol issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). Provider toolkits for office-based practice have been investigated, as well as models for presenting a symposium to providers on how to integrate buprenorphine treatment into primary care.

Data Analysis

Medicaid claims data have provided some useful information on current utilization patterns of buprenorphine patients. Looking at a recent twelve month period (9/1/04 – 8/31/05), it was revealed that 787 beneficiaries filled a prescription for buprenorphine during that time. Total expenditures for that group added up to over $10.5 million. However, expenditures related to an addictions diagnosis (including opiate dependency) were under $3.4 million, less than one-third of that total. Some of these beneficiaries

[5] Olson, J. Remarks at *Moving Toward Community and Healing,* 11/1/05.

were receiving buprenorphine from a primary care physician and some were under treatment with a specialist. However, this group had total expenditures approximately three times that of an average Medicaid cohort. This data indicates the enormous role for primary care physicians to address the substantial health care needs beyond addictions treatment for the opiate dependent population.

OVHA's Proposal

Targeted Provider Group

OVHA has decided that the most promising approach to increasing buprenorphine treatment capacity in Vermont is to target primary care physicians and practices. Indeed, the most revolutionary aspects of buprenorphine include that its use is well within the primary care scope of practice, and that it is not marginalized by the need for heavy regulation. Buprenorphine has been shown to work extremely well for those who may represent an active presence in primary care practices already; those whose addiction is of shorter duration, or those who abuse narcotic pain medicines and frequent primary care sites with drug-seeking behavior.

Capitation Rate/Enhanced Reimbursement

Currently, OVHA reimburses primary care physicians who provide buprenorphine treatment via a Fee for Service (FFS) model; paying on a visit by visit basis. When it comes to treating the opioid dependent patient in this manner two areas of concern arise: there is no financial incentive for practices to implement 'best practices' as this would in theory reduce the number of visits over time and secondly since these beneficiaries demonstrate a much higher than average "no-show" rate they are viewed by many as less desirable patients.

In this program, OVHA seeks to encourage primary care physicians to provide buprenorphine treatment by prepaying an enhanced capitated rate with an additional bonus based on participation rate. (Practices would be free to remain fee for service if they wish, or as a group choose to participate in this initiative, but not be allowed to do both depending on the individual patient). The enhancement would be predicated upon providers following a "Best Practices" protocol as established by ADAP and subject to review via Medicaid Claims data as well as office-based chart review. Although Vermont Buprenorphine Practice Guidelines have been available since August 1, 2003, there are no assurances that these guidelines in their totality are in fact being implemented within practices across the State. Participating practices would allow OVHA and the Division of Alcohol and Drug Abuse Programs to assist them in establishing microsystems, protocols and educational opportunities for the staff as well as the providers to achieve more readily "Best Practices" status.

The capitated rate would be based on two separate factors: the complexity of the patients a provider may be treating; and second, the absolute number of patients any provider is treating.

Patient Complexity would be assessed consistent with Vermont's Practice Guidelines into those requiring induction, stabilization or maintenance. Using approximate numbers of visits that "Best Practices" would mandate for each of these levels, a capitated reimbursement figure can be derived. For example: a patient in Complexity Level I (maintenance) might only require one or two office visits per month at the 10-15 minute rate whereas a Complexity Level III (Induction) patient could well need three to five office visits the first week followed by one to two office visits per week the rest of the month. This then would translate into the following using current Medicaid reimbursement numbers per month:

I. Maintenance only	99213 OV	(2) visits	$67.52
II. Stabilization	99213 OV	(6-8) visits	$202.56 - $270.00
III. Induction	99205 OV	(1) visit	$78.89
	99213 OV	(11) visits	$371.36 - $350.00

A bonus of 5% could be added for every multiple of five in the number of patients a provider has under his/her care. Thus a physician treating eight Level I patients would receive $594.17 per month (8 x $67.52 = $540.16 + (0.10 x 540.16)) whether those patients required more or less office visits than anticipated.

Complexity Level III is defined as that period of time in which the patient is first started on buprenorphine and would last a maximum of one month.

Complexity Level II is defined as that period of time immediately following Level III in which the correct dose of buprenorphine is titrated to the most clinically effective amount and would last a maximum of two months.

Complexity Level I is defined as that period of time in which a stable dose of buprenorphine has been achieved, reflecting as well a stable clinical state of recovery on the part of the patient.

The proper assignment of a patient to any particular Complexity Level can be modified after an independent chart review of a care coordinator in consultation with OVHA's Medical Director.

Comprehensive Practice Supports

Without comprehensive practice supports, financial incentives are likely to have limited impact. Feedback from physicians, RNs, practice managers and support staff has all indicated that reimbursement is not the only issue preventing practices from offering this treatment. Practices fear being overwhelmed by the complex and time-consuming needs of patients with opiate dependence. Without the support of specialty resources and definitive tools and protocols, practices risk devoting an inordinate amount of time and staff resources to opiate dependent patients without commensurate therapeutic effect.

OVHA is collaborating closely with ADAP in ADAP's effort to promote best practice in this area through the provision of comprehensive practice supports. OVHA and ADAP

are committed to developing the tools, and practices will be required to take advantage of them in order to participate in the Capitated Reimbursement Program. The practice supports / requirements will be as follows:

- A written practice protocol, including:
  - Vermont Buprenorphine Practice Guidelines
  - Related office procedures
- Demonstrated use of a standardized toolkit which includes:
  - Informational materials for patients and family
  - Screening tools
  - Patient contracts
- Establish horizontal integration of services. Formalize a relationship with:
  - Mental Health and Substance Abuse Counseling services
  - Addiction consultant
  - Hospital / Emergency Department
- Participate in Care Coordination.
  - OVHA's regionally based care coordination initiative will provide RN / Medical Social Worker teams to assist practices with their most complex and high-utilizing patients, regardless of diagnosis.
  - ADAP care coordinators will also be regionally based by AHS service district. They will provide direct support to practices around the implementation of practice protocols, horizontal integration of services, minimization of possible diversion and assistance with individual patients on buprenorphine. They may also play a direct role in collecting and reporting back to practices on some data accessible only through chart review.
- Symposium
  - OVHA and ADAP will co-host a symposium in collaboration with other community partners in order to introduce the capitation program and provide detailed information and instruction on the comprehensive practice supports.

Registry

In keeping with the Chronic Care Model and the Blueprint, there is a desire to maintain a registry of those in treatment with buprenorphine to assist with clinical monitoring and track outcomes. Specific federal law complicates the use of a registry as a tool to manage a population whose illness may also indicate illegal activity. Currently the need for treatment service and appropriateness for office-based opiate treatment is coordinated through the Medication Assisted Treatment Program at Central Vermont Substance Abuse Services in Berlin, Vermont. All requests for medication assisted treatment are being referred to Yvette Stevens, MA, LADC, Program Coordinator, who maintains a waiting list and who also starts the process of identifying waivered physicians in the community who will assume care of the patients following evaluation and induction.

Proposed Benchmarks

OVHA intends to measure a number of benchmarks in order to assess the program's success in increasing access to buprenorphine treatment for Medicaid beneficiaries. Proposed benchmarks include:

- Number and specialty of licensed buprenorphine prescribers
- Number of patients in active treatment
- Number of patients per prescribing physician
- Utilization profiles of buprenorphine patients.
- Rates of incarceration/reincarceration for buprenorphine patients.
- Retention in treatment
- Compliance with medication regimen
- Clean urines
- Length of treatment
- Related indicators of recovery such as employment, housing

Potential Barriers

Claims Data Reliability

Claims data is a useful tool, but it has inherent limitations. It is unable to provide chart-based clinical information that is essential for measuring treatment outcomes. Direct access to patient records is the only way to get actual test results and a full clinical picture for an individual. Claims are also dependent on accurate and complete coding for true utility. For example, physicians sometimes treat opiate dependency under a co-occurring psychiatric diagnosis. In addition, the current Medicaid claims database only has access to a primary diagnosis on a claim. If there are multiple diagnoses listed for co-occurring disorders, the system does not currently have a way of displaying that.

Primary Care Physician Resistance

There are multiple and extensive pressures on primary care practitioners in the current health-care system. There are financial pressures brought to bear by cuts in reimbursement and liability insurance costs. There are also concerns that Pay for Performance programs will heighten that financial pressure. The small private practice model that predominates in Vermont is most vulnerable to these financial pressures and has the least support infrastructure. This proposal attempts to consider these pressures by incorporating some of the feedback given by apprehensive physicians. However, the challenge will remain to convince primary care physicians state-wide that participating in enhanced treatment options for opiate-dependent Medicaid beneficiaries is a clinical responsibility and community service that they are equipped to perform.

Limiting the Opportunity to Primary Care Practices

The strategic decision was made to design a program around primary care for two fundamental reasons. The first is that psychiatrists and primary care physicians bill

different codes at different rates for a different type of service. The same plan could not be applied equally in both types of practices with the same level of enhancement. Most importantly, this program was designed to take advantage of the major treatment opportunity that buprenorphine provides. It brings medication-assisted therapy for opiate addiction to the stigma-free environment that patients already know, and allows that treatment to take place in the context of the patient's medical home. This means access and holistic care at a level that psychiatry and treatment programs do not provide.

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Appendix B: Steps to Promote Successful Community Reentry for Incarcerated Individuals with History of Opiate Addiction

The problems of substance abuse and crime are deeply entwined. According to the Bureau of Justice Statistics, 80%t of the incarcerated population in the United States has a history of substance abuse.[6] Vermont's Department of Corrections (DOC) had 7474 substance abuse treatment admissions in 2005. However, the prison population in Vermont is highly mobile. The DOC experiences a 50% turnover in population every 60 days.[7] Therefore, in many cases a treatment program is incomplete when an inmate is released. Returned to their former environment without the resources to manage their addiction, these individuals are at high risk for re-incarceration. For individuals who participated in, but did not complete, the Intensive Substance Abuse Program (ISAP) between 1999 and 2002, there was a 47% reconviction rate three years after release. However, 33% of the individuals who completed the program were reconvicted within three years of leaving prison.[8] A system that provides a smooth transition from prison to community-based treatment for incarcerated individuals with a history of substance abuse needs to be implemented. For those struggling with opiate addiction, OVHA's Buprenorphine Access Project may provide that critical support.

OVHA proposes the following additional steps to facilitate access to buprenorphine treatment for opiate-addicted individuals due to be released from prison:

1) **Allow primary care doctors to bill under the highest capitated rate for treatment of patients coming out of prison in the first month.**
   This would allow practices to bill as if they are providing initiation of buprenorphine treatment (which is clinically complex and requires almost daily monitoring) for patients who received induction while still in prison. The goal is to provide additional financial incentives for practices to commit to these patients.

2) **Pay for a practice representative to perform a needs assessment in prison prior to release.**
   For practices that have an interest and the staff availability, OVHA would reimburse for pre-release needs assessment to be conducted in prison. The goal would be to establish the relationship between the inmate and the practice in order to increase the likelihood that the inmate would follow through with the initiation of care once he is free in the community.

3) **Collaborate with DOC to get appropriately screened individuals started on buprenorphine prior to release.**
   OVHA would seek to encourage more physicians within the prison health system to obtain buprenorphine waiver licenses and become clinically comfortable with buprenorphine induction for appropriately screened patients. OVHA would work

[6] Council of State Governments Re-entry Policy Council. *Charting the Safe and Successful Return of Prisoners to the Community.* 2/05.
[7] Susan Wehry, MD personal communication, 10/7/05.
[8] VT DOC Facts and Figures, 2005.

to facilitate access to addiction consultations. OVHA would assist DOC in exploring reimbursement strategies for the cost of the medication, including mechanisms potentially provided by the Global Commitment to Health waiver, such as funding a grant for a pilot project.

4) **Enlist the help of ADAP care coordinators to arrange wrap services.**
The ADAP care coordinators could also meet with the individual prior to release in order make an assessment of ongoing treatment needs. They could be that initial link to the primary care practice in cases where this arrangement would be more feasible. They could also provide the link to other necessary treatment resources such as group therapy and Narcotics Anonymous.

5) **Collaborate with DOC and the Department for Children and Families (DCF) to have Medicaid coverage established or re-activated in time for the day of release.**
When a Medicaid beneficiary is incarcerated, Prison Health Services (PHS) becomes the provider of health care benefits. Assuming that there are no anticipated changes in income or access to private benefits, there should be a simple mechanism in place to simply reinstate the individual's Medicaid benefits upon release. This is an essential step in order to guarantee access to a medical home and continuity of buprenorphine treatment established in prison.

Appendix 8: Pharmacy Best Practices and Cost Control Report 2006

Overview

Vermont's health insurance programs covered 148,000 beneficiaries monthly in state fiscal year (SFY) 2005. Some of these programs include full health insurance coverage. All of them include a pharmacy benefit. These programs are:

- Medicaid
- Dr. Dynasaur
- VHAP
- VHAP-Pharmacy
- VScript
- VScript Expanded
- Healthy Vermonters
- VPharm

Pharmacy spending is the top spending item in Vermont's publicly funded programs. In SFY '05, gross spending was $191 million, a 24.3% increase from SFY '04. With relatively little change in caseload, the reasons for this increase are specifically related to product cost and beneficiary utilization. Between SFY '04 and 2005 claims history showed the following:

- a 20.4% increase in product costs,
- a 12.6% increase in the number of prescriptions fills and refills, and
- a 12.6% increase in the total days supply.

Critical Issues

At all times, the goal of the Vermont Health Access Pharmacy Benefit Management (PBM) Program is to assure the availability of clinically appropriate services at the most reasonable cost possible. To do that the program faces the challenge of counteracting the impact of manufacturers who advertise nationally and locally. The Office of the Vermont Attorney General has estimated that $3.11 million was spent in marketing in Vermont alone in SFY '04. This advertising creates a situation where it is necessary to distinguish between what may be wanted and what is needed. At stake is preserving the benefit for people in Vermont's programs to the greatest extent possible.

Strategies

The Vermont pharmacy best practices and cost control program was authorized in 2002 by the State Fiscal Year Budget Act and Act 127. Operationally referred to as the Vermont Health Access Pharmacy Benefits Management (PBM) Program, it is administered by the Office of Vermont Health Access (OVHA). It includes Maximum Acquisition Cost (MAC) pricing; application of the generic drug requirements authorized by Title 19, Chapter 91 of the Vermont Statutes; messaging at the pharmacy point of

sale during drug claims processing; prospective and retrospective drug utilization review (DUR); prior authorization (PA) requirements; and a preferred drug list (PDL).

The PDL is a key feature in the PBM Program. The PDL identifies drugs that are clinically effective, but less costly. The PDL is the core of the programs' benefit design. If a drug is not listed as "preferred" in a particular category on the PDL, it requires prior authorization in order for the drug to be covered.

The PDL was developed with the help of the Drug Utilization Review (DUR) Board acting as the program's Pharmacy and Therapeutics (P&T) Committee. The board consists of Vermont doctors and pharmacists. The PDL features clinically appropriate, low-cost options that include generics, lower cost brands, and brands where manufacturers pay rebates supplemental to required Medicaid rebates to make their products affordable.

In March 2002, the first iteration of the PDL was completed, with PA required for any drug not identified as "preferred" in designated PDL classes. Starting on September 30, 2002, additional classes were systematically rolled out though December 9, 2002. With that, the groundwork of the PDL was set. Since then the PDL has been managed to reflect changes in clinical approaches, prescribing practices, product availability, and rebate opportunities. In regards to the latter, in the spring of 2003 Vermont joined a multi-state Medicaid pooling initiative that combined the purchasing power of Vermont with other states in negotiating supplemental rebates with pharmaceutical companies. While Vermont has changed its pool membership since, this continues to be an important strategy in the PDL in containing costs.

Benefit Management Operations

Major components in the operations of the PBM program are educating providers, messaging pharmacies during claims processing on utilization events, and applying prior authorizations requirements on drugs non-preferred for clinical or cost reasons.

Educating Health Care Providers

The Vermont Health Access Program relies on the DUR Board for advice on how to best educate providers. The DUR Board meets as often as monthly. In 2005 the Board met ten times, every month except February and December.

In the course of activities, the DUR Board may select certain drugs and/or prescribing practices to target for review of actual use and/or application. Staff makes recommendations for targeted areas and the board selects those they feel are most relevant. When this occurs, specific providers are polled regarding the patients affected and the board reviews their responses to determine if any follow up is appropriate either with the identified prescribers or with a clinical advisory to all providers.

To educate providers on PBM Program coverage activities, various methods have been used. Most frequently, mailings are prepared around both general and specific changes

and they are targeted to prescribers and pharmacies separately. These include changes to the PDL, the criteria for the authorization of non-preferred drugs, clinical advisories and alerts, and rebate activities. These mailings are also sent electronically to provider affiliates and representatives; for example, the Vermont Medical Society and the Vermont Pharmacists Associations. These organizations use their proprietary methods to distribute the materials. Information is transmitted electronically by OVHA where email addresses are made available by the provider. All drug related materials in mailings are posted on the OVHA web page (www.ovha.state.vt.us); specifically, on the web page for the Preferred Drug List and Drugs that Require PA located at www.ovha.state.vt.us/Preferred_drugs.cfm. The PBM Program is described at www.ovha.state.vt.us/PharmBeneHome.cfm. DUR Board meeting information and minutes are posted on the DUR Board web page at www.ovha.state.vt.us/DRU_home.cfm. Pharmacy specific information can be found on the Provider Services and Claims Processing: Pharmacy Services web page located at www.ovha.state.vt.us/ProviderPharmacyServices.cfm.

In the event of changes in the program affecting specific beneficiaries, prescribers are provided with two tools based on the recommendation of the DUR Board. One is a list of all the patients that were prescribed the specific drug that is being changed to non-preferred status. The second is a patient profile specific to each patient with their drug changes listed. This creates a record for use in the patient's file.

Utilization Review Events

Pharmacies are messaged at the time of claims processing on specific utilization issues. The selected potential issues are drug-drug interactions, early refills, therapeutic duplication, ingredient duplications, drug disease interactions, geriatric precautions, and other. The drug-drug interactions, early refills, and therapeutic duplication edits require the pharmacist to override or otherwise resolve the potential problem in order to fill the prescription. The other messages alert the pharmacist to potential issues, but do not require intervention to fill the prescription. The incidence of these issues in SFY '05 is reflected in following chart:

	Q1 SFY '05	Q2 SFY '05	Q3 SFY '05	Q4 SFY '05	Totals	Percent
Drug-Drug Interaction (DD)	169,568	174,348	154,315	159,856	498,231	18.6%
Early Refill (ER)	77,672	83,626	84,742	84,076	246,040	9.2%
Therapeutic Duplication (TD)	169,472	171,515	136,910	139,383	477,897	17.8%
Ingredient Duplication (ID)	66,395	66,478	55,769	57,059	188,642	7.0%
Drug-Disease (MC)	145,619	152,456	143,948	148,214	442,023	16.5%

	Q1 SFY '05	Q2 SFY '05	Q3 SFY '05	Q4 SFY '05	Totals	Percent
Geriatric Precaution (PA)	254,327	258,570	245,142	249,864	758,039	28.3%
Other	24,165	23,627	20,385	18,978	68,177	2.5%
Totals	907,218	930,620	841,211	857,430	2,679,049	100.0%

Prior Authorization Requests

The incidence of prior authorization requests in SFY '05 is reflected in following chart:

	Q1 SFY '05	Q2 SFY '05	Q3 SFY '05	Q4 SFY '05	Totals	Percent
PAs Requested	11,566	11,286	10,197	9,383	42,432	100.0%
PAs Approved	10,172	10,582	8,559	6,826	36,139	85.2%
Drug Changes on PA Request	1,289	1,223	1,487	1,330	5,329	12.6%
PAs Denied	105	65	74	92	336	.8%
Totals	23,132	23,156	20,317	17,631		

SFY '06 Pharmacy Related Budget Projects

The following are budget projects for SFY '06

- Review and update the PDL/increase generic utilization
- Manage mental health drugs
- Educate to appropriate greater day supply
- Apply maintenance definition to VScript
- Implement select Pharmacy Mail Order
- Apply pharmacy fee

Review and Update the PDL/Increase Generic Utilization

A complete review of the PDL with the DUR Board was initiated in April 2005. The review continued during monthly DUR Board meetings with classes selected for each meeting. The review was completed in October 2005. Additional updates occurred in January to reflect supplemental rebate changes. Changes were implemented after approval by the DUR Board.

The board is adamant in its commitment to promoting generics wherever possible. As a result, generics are prominent is the selection of preferred drugs. The percentage of generics used as a percentage of drug type was 54.55% in November 2005. This was a modest increase over November 2004 when it was 53.78%. The rate of use of generics when generic equivalents are available is high. The rate use when generic alternatives are available is the area where it is believed there is the greatest opportunity.

With the PDL now fully reviewed next steps will include its active promotion including instituting education and outreach activity with providers.

Manage Mental Health Drugs

Since the implementation of Vermont Health Access Pharmacy Benefit Management Program in 2002, drugs used to treat severe and persistent mental illness (SPMI) have been exempt from management. All other major cost categories of drug treatment are under management. In SFY '05, 31.7% of the total drug spending was for mental health drugs.

This year, the administration's proposal to manage SPMI drugs was approved in Act 71 subject to the review of the Program's Drug Utilization Review Board. This review was to include:

- an analysis of prescribing patterns,
- expenditure trends,
- literature,
- algorithms,
- options in lieu of formularies/preferred drug lists/prior authorization; for example, the Missouri retrospective review project,
- testimony regarding clinical efficacy and outcomes,
- any proposed revisions to the PDL regarding drugs used to treat mental illness; and
- an analysis of assurances that a beneficiary in treatment would not be required to change medication such that there would be a risk of psychiatric destabilization.

The review was completed and presented to the DUR Board in August 2005. It was agreed that mental health drug classes could be managed through the Preferred Drug List (PDL). The proposed PDL changes identified the most cost-effective, clinically appropriate drugs in specified classes. These drugs included generic equivalents and alternatives as well as other low cost alternatives. More expensive alternatives would be available with prior authorization using criteria developed through literature review of acceptable standards particularly the Texas Algorithm (TIMA), the International Psychopharmacology Algorithm Project (IPAP), class reviews from the Oregon Evidence Based Practice Center, the Veterans' Administration, and the Micromedex® Health Series. Authorizations would use pharmacy claims history wherever possible to determine if the criteria had been met to minimize the impact on prescribers who would otherwise have to request an authorization.

The board recommended that certain beneficiaries' active treatment should be "grandfathered in" so as not to risk destabilization. It was decided that patients of all ages currently using antipsychotics, antidepressants, and/or mood stabilizers would continue to use existing drug therapies. Lapses in treatment of four months or longer or changes in treatment will result in the application of the PDL and its clinical criteria. The PDL and the criteria would apply to all new patients.

In addition to the PDL, the program would simultaneously monitor best-practice reports; track utilization; explore prescribing options (for example, dose optimization, pill splitting, etc); and partner with contractors, prescribers, and insurers in educational and detailing activities including Missouri-like approaches.

A report on the review and the board's deliberations was submitted to the Legislature's Health Access Oversight Committee (HAOC) for comments or recommendations on September 1, 2005. The Committee heard testimony from prescribers and advocates. As a result they recommended that Central Nervous System (CNS) Agents used to treat ADHD be included in the "grandfathering" provisions. This recommendation was approved at DUR Board meeting in September.

A claims processing implementation plan was developed, provided to the DUR Board, and further reviewed with the Medical Director of the Division of Mental Health (DOH) and the DUR Board's psychiatrist member. The plan was successfully implemented in January 2006.

Educate to Appropriate Greater Day Supply

Practice allows maintenance drug coverage of 90 days for VScript beneficiaries and 102 days for all other beneficiaries. However, in December 2004, only 4.9% of claims were for periods of greater than 34 days. Filling claims monthly results in increased revenues to pharmacies in the form of dispensing fees. In April 2005, OVHA began attempting to promote the use of a greater day supply when it was clinically appropriate. Little success was achieved. In the quarter ending September 30, only 5.1% of claims were for periods of greater than 34 days.

While OVHA had intended to aggressively market the increased days supply, Medicare implementation events intervened. The Centers for Medicare and Medicaid Services (CMS) began to encourage states to provide Medicare beneficiaries with state coverage for a ninety day supply in December. While that would have ameliorated many Medicare Part D implementation issues, the result would have been Vermont systematically paying for coverage twice for many beneficiaries, once in the extended fill and once in clawback. No portion of such a duplicate payment would have been subject to any recovery.

Once Medicare Part D matters are resolved the extended fill process will be pursued. In the meantime, OVHA continues to recommend that prescribing be for whatever period is clinically appropriate.

Apply Maintenance Definition to VScript

VScript was implemented in 1989. At the time pharmacies were permitted to designate what drugs were for "maintenance use". In this last year clinical staff reviewed utilization and identified therapeutic drug classes that would not be used for maintenance purposes. In September of 2005 the Drug Utilization Board reviewed the list of classes considered non-maintenance and approved those classes that were believed to be never used for maintenance purposes.

Statutory language required a rule change in VScript policy to apply this change. The change was effective January 1, 2006.

Implementation occurred on January 1, 2006. Since that time, cases have been identified where certain drugs generally not used for maintenance purposes are used that way for individual beneficiaries. Procedures have been developed to allow a prescriber to request an authorization for an exception.

Implement Select Pharmacy Mail Order

The Budget Proposal for SFY '06 included the implementation of select mail order options. This was not intended to be a plan for full mail order operations. Proposed targets include:

- Diabetic supplies
- Multiple sclerosis drugs
- Growth hormone drugs
- Hemophilic drugs
- The drug Synagis® used to treat respiratory synctial virus, a respiratory ailment unique to newborns that are born prematurely.

In the spring of 2005, OVHA included proposals on mail order options as part of a Pharmacy Benefit Manager (PBM) contract procurement. The resulting proposals demonstrated that the best price can be obtained through a separate procurement. The category with the greatest expenditures is diabetic supplies, with the majority of beneficiaries who are elderly or disabled. With the implementation of Medicare Part D, many of these beneficiaries will receive their primary benefit from Medicare. OVHA plans to release a RFP for Mail Order services for these specialty drugs once Medicare Part D is fully functional.

Apply Pharmacy Fee

A pharmacy fee program was implemented for claims processed beginning in July 2005. Payments were first received in September. Some pharmacies had early difficulties in reporting the number of claims they processed. These problems are now largely resolved. At the request of pharmacies, an analysis is underway to compare the tax paid by each pharmacy to date to the revenues generated by the increase in dispensing that applied effective July 1, 2005.

Other Activities

New Pharmacy Benefits Administrator

In March 2005 OVHA issued a Request for Proposal to provide pharmacy benefits management (PBM) services for Vermont's publicly funded programs. The existing contract with First Health Services Corporation of Glen Allen, Virginia was due for renewal. While that contract could have been extended, it was felt that with the number of needed pharmacy initiatives that were critical to immediate budget needs, the immediate advantages and potential opportunities in care management in existing operations and those under the Global Commitment, and the planned implementation of the Medicare Part D benefit, that it would be wise to explore a new contract. The intention was to assure that we had the appropriate resources to adequately respond to our developing environment.

Pharmacy benefit management (PBM) unique services include:

- Claims Processing
- Coverage Management
- Utilization Review and Management
- Analysis and Reporting
- Rebate Management
- Support Services.

Claims processing supports 231 pharmacies enrolled in Vermont's programs. Vermont pays 2.5 million claims per year. Management of the pharmacy benefit applies to 148,000 program beneficiaries including the wraparound benefit for the Medicare Part D eligibles.

In September 2005, OVHA selected a new Pharmacy Benefits Administrator (PBA), MedMetrics Health Partners of Worcester, Massachusetts. MedMetrics is a non-profit, full-service pharmacy benefit manager, wholly owned by Public Sector Partners (PSP) and affiliated with the University of Massachusetts Medical School and the University of Massachusetts Memorial Medical Center. MedMetrics currently provides Drug Utilization Review services for the Commonwealth of Massachusetts; pharmacy benefit management services for the Massachusetts Medicaid program through a designated managed care organization, Neighborhood Health Plan; and program management and benefit coordination services for Massachusetts' State Pharmacy Assistance Program. As such they are a regional presence with clinical, pharmacy, and Medicaid experience.

This selection will permit a partnership with an opportunity to create the next generation of its Vermont Health Access Pharmacy Benefit Management Program.

New Supplemental Rebate Purchasing Pool: The Sovereign States Drug Consortium

With the transition to a new pharmacy benefit administrator (PBA), Vermont needed an alternative to the National Medicaid Pooling Initiative (NMPI) managed by Vermont's previous PBA, First Health Services Corporation. OVHA is now working with Iowa,

Maine, and Utah on the first in the nation state-administered Medicaid pooling initiative for supplemental rebates, the Sovereign States Drug Consortium (SSDC).

A number of other states are considering the Consortium. In it, member states will be able to pool collective lives as well as state staff and pharmacy benefit management contractor resources to negotiate supplemental rebate agreements with drug manufacturers. This approach will provide much administrative efficiency. It will also result in greater state involvement with the actual agreements in assuring state unique drug coverage customization. For the future, this will provide greater opportunities for multi-state collaborations in publicly funded health insurance arenas. This also creates a pool that is not dependent on a single contracted vendor.

On October 15, 2005, OVHA mailed notices to all drug manufacturers with current Vermont supplemental rebate agreements providing them with the opportunity to enter into new agreements. To facilitate the transition from the NMPI, those with existing agreements were given two options. They could negotiate with Vermont directly or they could opt to immediately participate in the Sovereign States Drug Consortium (SSDC). This arrangement was offered to allow these manufacturers who have already shown a commitment to Vermont choice in our continued relationship. Other manufacturers could only participate through the SSDC and the SSDC announced the opening of the bid period to all manufacturers with an October 26, 2005 mailing.

The first SSDC negotiation cycle is now complete. In the NMPI, Vermont had agreements with sixty manufacturers. Under the SSDC, Vermont has secured bid offers from forty-nine of those sixty manufacturers and from an additional twenty-five manufacturers. The eleven or the original sixty who did not bid are not a concern because they represented low use products. To illustrate, for the last billed quarter prior to the SSDC bid cycle, the second quarter of calendar year 2005, their total billed amount was a negative $4,417.76, representing past period adjustments.

Final product selection is complete. In some cases because of the lesser number of lives in the SSDC, the bid offers, products, and price are less. In other cases, they are better because of utilization. In still other cases, the bids reflect the expectation that utilization will be significantly different with the transition of our beneficiaries who are Medicare eligibles to Part D. However, it is clear that manufacturers are very willing to participate in this new pool and an analysis of the offerings indicates that Vermont will do at least as well under the SSDC as we would have under the NMPI with reduced revenues commensurate with the reduced expenditures that result from the transition of many users to Part D.

Implementation of VPharm

Act 71 created VPharm in response to the start of Medicare Part D. VPharm became operational January 1, 2006 for 30,000 Vermont program eligibles. It was effectively suspended with the January 6th reinstitution of pre-January 1 coverage in the face of Medicare implementation problems. However, ultimately with VPharm, people eligible for both Medicare and Medicaid, or Medicare and a pharmacy program, will get their

primary drug coverage from Medicare. VPharm creates a secondary coverage wrap benefit to ensure that beneficiaries get coverage comparable to what they had from Vermont's program at a comparative cost.

Appendix 9: Actuarial Certification

To be Distributed at a Later Date

Appendix 10: The Vermont Blueprint for Health

The Vermont Blueprint for Health is a statewide initiative that provides Vermonters who have chronic conditions with the information, tools and support they need to successfully manage their health.

Chronic conditions are the most serious (and most costly) health problem facing Vermont today—and unless we act now, the problem will only get worse. The leading chronic conditions in Vermont include heart disease, diabetes, asthma, hypertension, depression, cancer, liver disease and emphysema. All are serious conditions that, left untreated, can lead to the need for acute and/or emergency care—typically the most expensive and complex care of all.

And yet, most chronic diseases can be prevented, and when they do occur, can be successfully controlled by better lifestyle choices, regular medical monitoring, early treatment and/or appropriate medications.

Inaugurated in 2004, the Vermont Blueprint for Health is off to a positive start and is already making a difference in several Vermont communities. Continued support for the Blueprint will assure that more Vermonters will benefit, helping not only to improve their health but also controlling the escalation of health care costs in our state.

The increasing number of Vermonters who experience serious health complications from chronic conditions, and the escalating cost of their care, demands a response. The Vermont Blueprint for Health is built on the premise that prevention and improved chronic illness care will benefit the state and its people in three important ways:

1) **By promoting healthy lifestyle options and prevention efforts, including support for infrastructure changes to foster active communities.**
2) **By helping Vermonters to live longer, healthier lives through appropriate and timely medical treatment and sound lifestyle choices.**
3) **By reducing overall demand for medical treatment services, many of which are currently funded through state programs, can lead to significant savings to the state and its residents.**

The Vermont Blueprint for Health is based on the Chronic Care Model developed by Dr. Edward Wagner as part of the Improving Chronic Illness Care (ICIC) program of the Robert Wood Johnson Foundation, and on the work of Dr. Donald Berwick of the Institute for Healthcare Improvement. The Chronic Care Model integrates public health expertise with clinical health care delivery systems in order to deliver “the right care at the right time.”

The Blueprint vision is that *Vermont will have a statewide system of care that improves the lives of individuals with and at risk for chronic conditions*. Change of this magnitude requires action at all levels, but most critical is that change must happen where people live, work and play and where they receive their health care.

Community-focused initiatives were begun with two pilot communities in 2005 in Bennington and St. Johnsbury. Additional communities will have the same opportunity in 2006, with more added each year until the entire state is covered.

Self-management is the cornerstone of day-to-day care for all chronic conditions. Everyone can become good self-managers and make *smart choices* if they have the *powerful tools* of information, skills and support they need. Expectation: Every community will offer the Healthier Living Workshop throughout the year in multiple locations. The Healthier Living Workshop is a program that has been demonstrated to be effective in helping people better manage their health and reduce their use of expensive services. Necessary aspects include:

- Identify a local leader to manage all logistics and link to the Department of Health.
- Ensure a cadre of lay and professional staff to be trained to offer the Workshop.
- Recruit participants for the Workshop.
- Coordinate with disease specific self-management programs offered in the community such as the American Diabetes Association "Learning to Live Well with Diabetes".
- Link with provider practices and other Blueprint for Health activities in the community.

Community activation and support is a *powerful tool* in helping people make and sustain the *smart choices* that will make them healthier. Walking programs have been demonstrated to have a positive effect on health and will be the first programs developed in the community. Expectation: Vermont communities will implement programs and share information about the availability of services that support a healthier lifestyle. Necessary aspects include:

- Identify a local leader to manage community physical activity programs and link to the Department of Health.
- Establish or expand walking groups to provide friendship and support in all towns with a population of 2000 or more.
- Establish a program for individual "contracting" with another person (friend or family member) to complete specified levels of physical activity daily or weekly.
- Develop an outreach/marketing strategy to encourage participation.
- Link with provider practices and other Blueprint for Health activities in the community.
- List the walking program(s) and other healthy living programs with Vermont 211 and include the website in marketing materials.

Include one or more of the following environmental or policy strategies:

- Improve the physical environment to make use of trails and sidewalks more attractive such as landscaping, improved lighting and safety improvements.
- Distribute maps of desirable walking or biking routes in your community.
- Advocate for spaces to be available during "off hours" such as schools or malls being open before or after business hours.

- Work with constituents, partners, and town planners to improve, create, and/or build facilities such as walking trails, sidewalks, bike paths or other facilities.

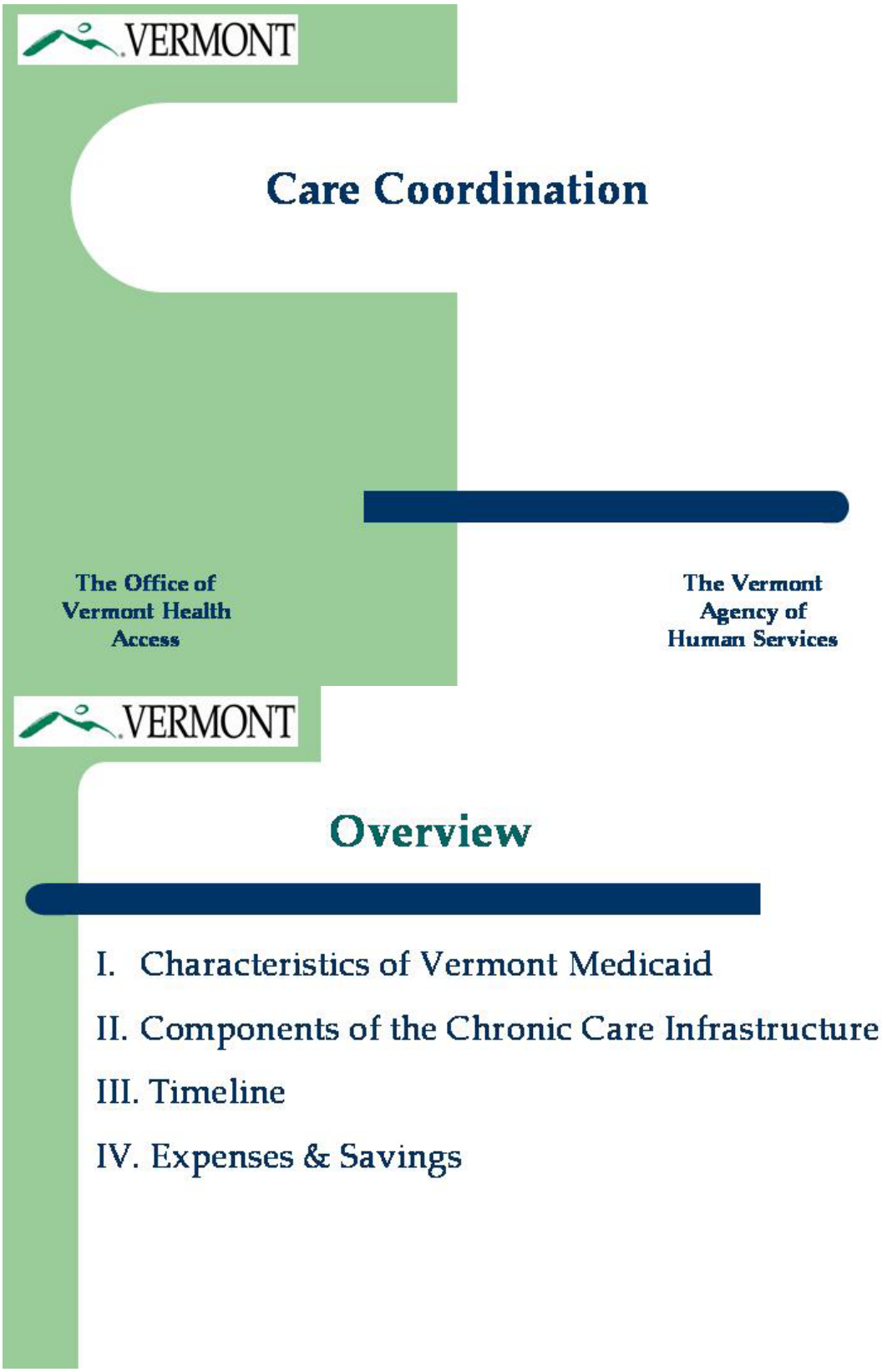
Physician and other health care providers must also adopt new, more *powerful tools* to deliver the right care at the right time to people with chronic illnesses. Expectation: Improved office systems, good decision support and an integrated health information system will be available to help health care providers deliver proactive care. Necessary aspects include:

- Identify a local provider champion to assist with provider recruitment, training and participation in the Blueprint and link to the Department of Health.
- Recruit 75 percent of primary care practices in the area to participate.
- Coordinate training for participating providers and practice staff.
- Provide financial support for participating practices to offset the costs of implementation.
- Link provider practices with the Healthier Living Workshops, walking programs and other Blueprint for Health activities in the community.

Information Technology (IT) is the most *powerful tool* to enable health care providers to monitor patient needs and support clinical decisions. Expectation: Communities will promote participation by local providers in the statewide Chronic Care Information System (CCIS) that supports implementation of the Blueprint. This includes:

- Identify a local IT lead to assist with technology requirements for automated data feeds into the local Electronic Medical Record and the Vermont Health Record.
- Facilitate provider engagement and implementation of the information system to proactively identify and manage individuals with diabetes, and track clinical results.

Appendix 11: Care Coordination Presentation



VERMONT

The Case for Care Coordination

VERMONT

Poverty is a qualifying criteria.

- Approximately 92 % of Vermont Medicaid beneficiaries are low income.

2005 HHS Poverty Guidelines

Persons in Family Unit	Threshold Income
1	$9,570
2	12,830
3	16,090
4	19,350
5	22,610

Federal Register, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

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Disability is a qualifying criteria.

- The *Traditional Medicaid* population includes the Aged, Blind, and Disabled (ABD) enrollment/eligibility group.
- In SFY 2004, there were 23,083 ABD beneficiaries.
- In SFY 2004, expenditures for ABD beneficiaries totalled $145,321,331.
  - Projected expenditures for 2005 = $166,904,824
  - Projected expenditures for 2006 = $181,780,644

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The burden of chronic illness on low-income Vermonters is higher.

Vermont Medicaid Chronic Illness Expenditures - 2004

CONDITION	DOLLARS	# OF UNIQUE RECIPIENTS
Depression	$19,567,505.00	34,362
CHF	$14,037,434.00	2,971
Diabetes	$10,648,661.00	6,912
Obesity	$1,578,489.00	4,482
Asthma	$576,757.00	1,887
TOTAL	**$ 46,408,846.00**	**50,614 ***

** This number may reflect beneficiaries in multiple diagnostic categories.*

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The burden of substance abuse is higher.

- Over 60% of admissions state-wide for substance abuse treatment were for Medicaid beneficiaries.
- $3.3 million was spent on substance abuse services for the 787 beneficiaries who received at least one prescription for Buprenorphine.
- These 787 beneficiaries accumulated an additional $7 million in medical expenses.

** 12 month period: September 1, 2004 – August 31, 2005.*

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Josephine*

- Josephine is a 35 year-old mother of 2 who is currently separated from her incarcerated husband, and is employed at a low-wage food service job.
- Josephine has 7 chronic conditions: ***Morbid obesity, Type II DM, Severe Leg Varicosities, Migraines, Severe Iron-Deficiency Anemia, PTSD, Depression, Severe Anxiety.***
- Josephine is taking 7 different medications: ***Lexipro, Prevacid, Trazadone, Clonazepam, Phenergan PRN, Ibuprofen PRN, Ferrous Gluconate TID.***
- Josephine was seen in the Emergency Room 10 times in 2005.
- Josephine has 4 providers managing her care: ***Primary Care Provider, Gastric Bypass Surgeon, Vascular Surgeon, Therapist.***

**NOTE: This is not a real person. Information is based upon claims data.*

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Why Choose Care Coordination?

Care Coordination maximizes health outcomes for complex Medicaid beneficiaries by ensuring access to a *coordinated* comprehensive treatment program.

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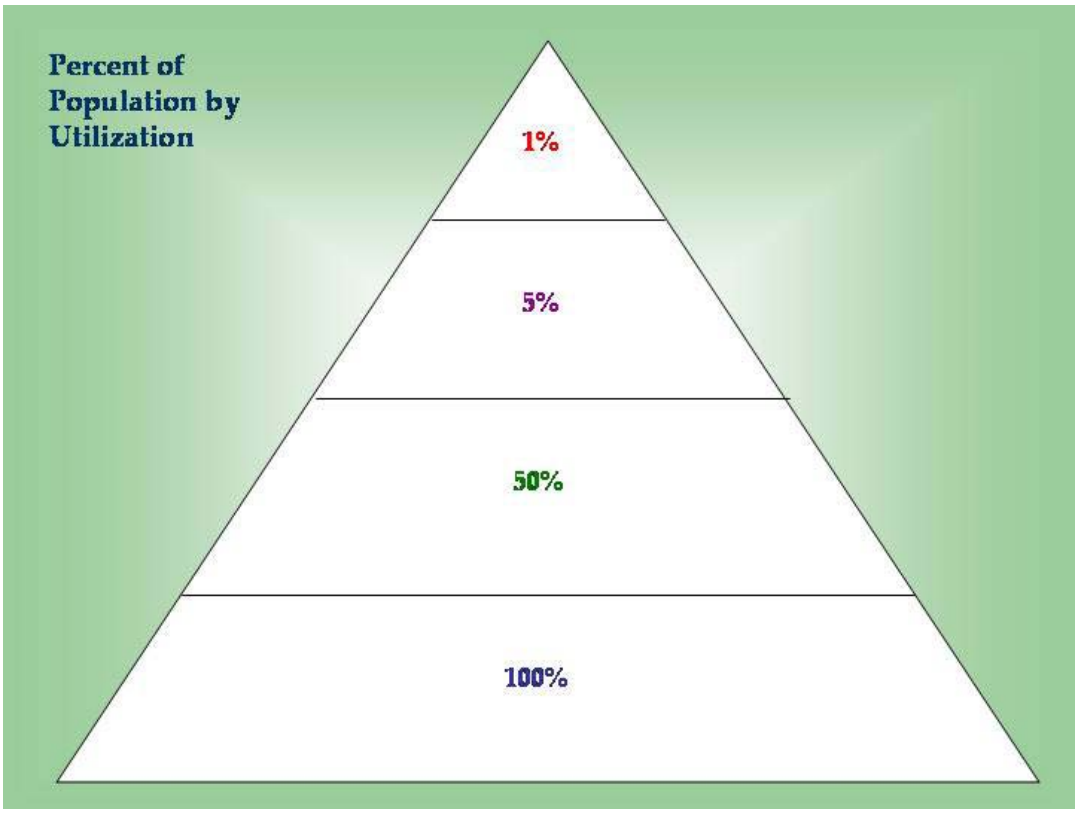
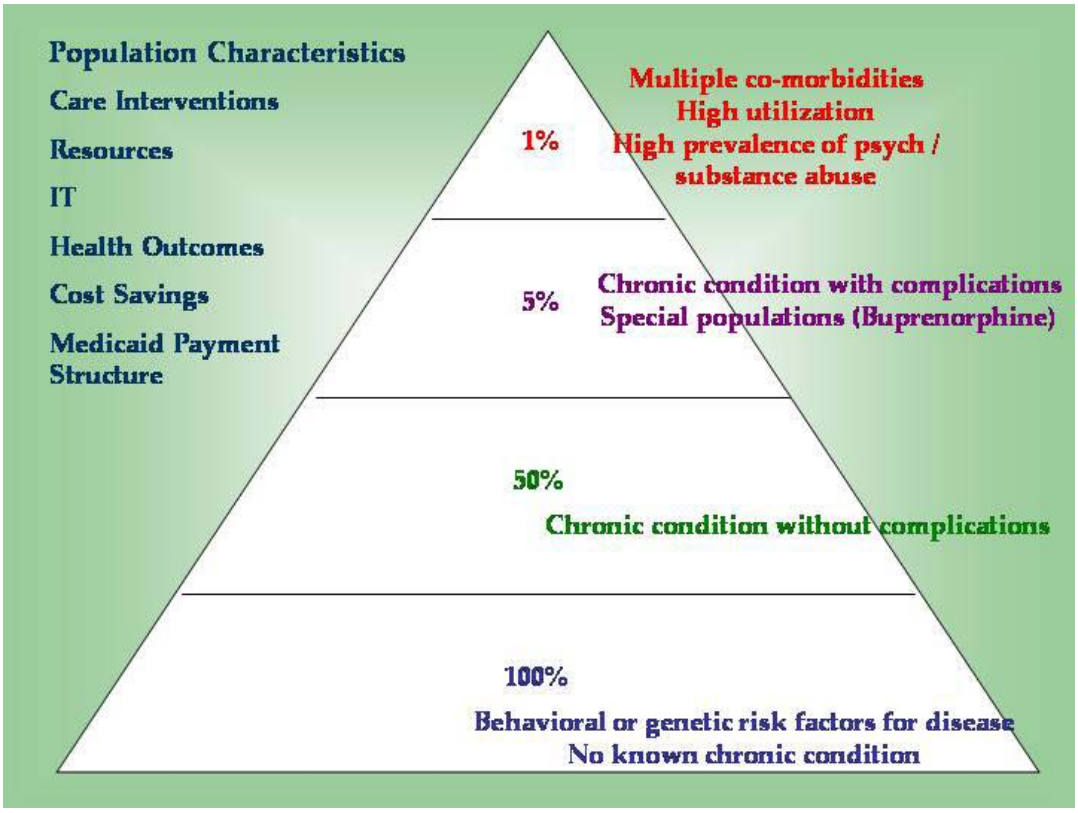
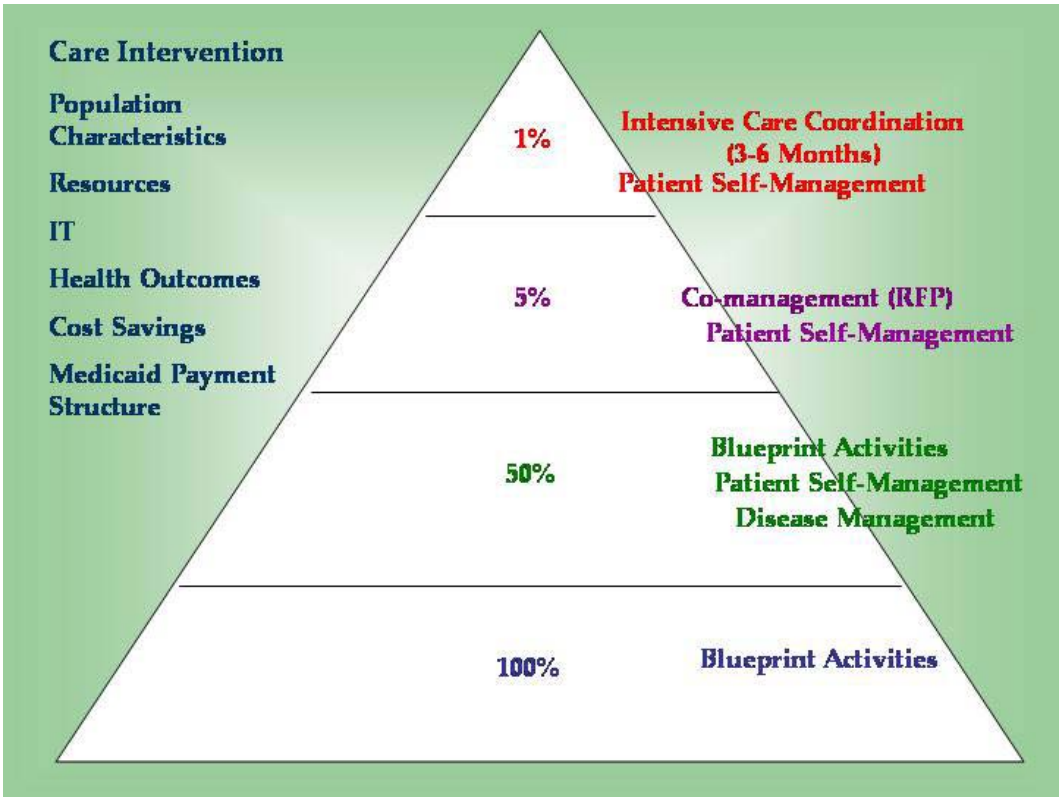
Key Components of a Chronic Care Infrastructure

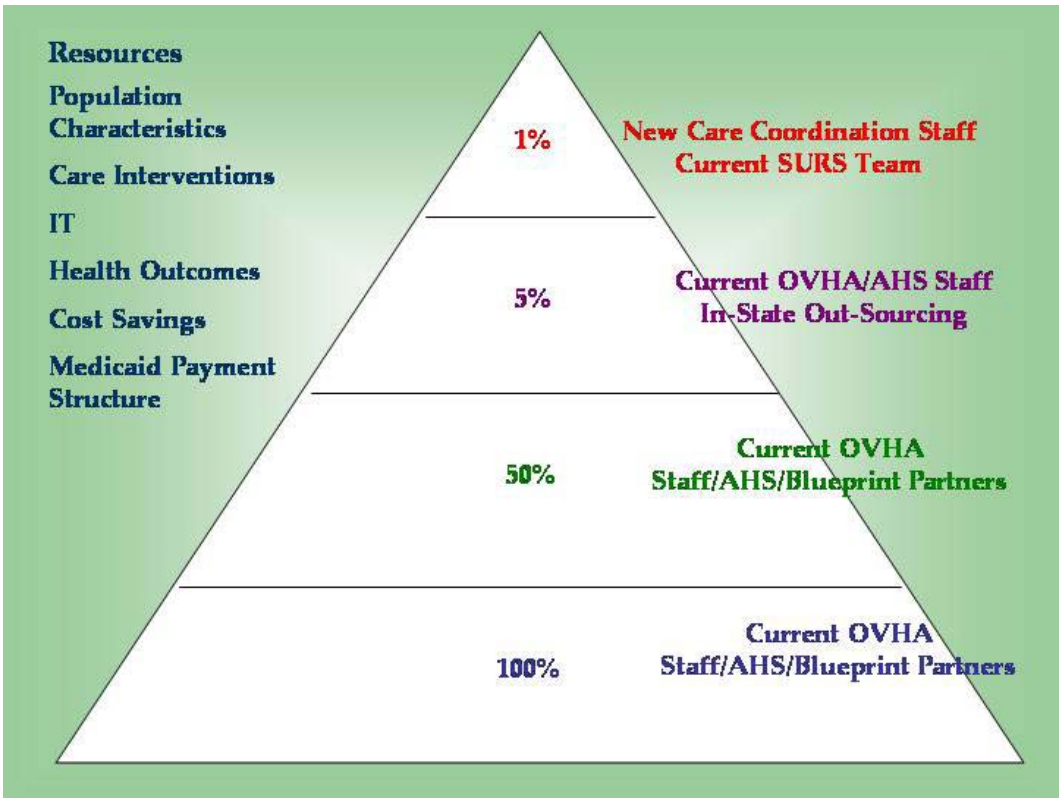
1. Population Characteristics
2. Care Interventions
3. Resources
4. IT
5. Health outcomes
6. Cost Savings
7. Medicaid Payment Structure

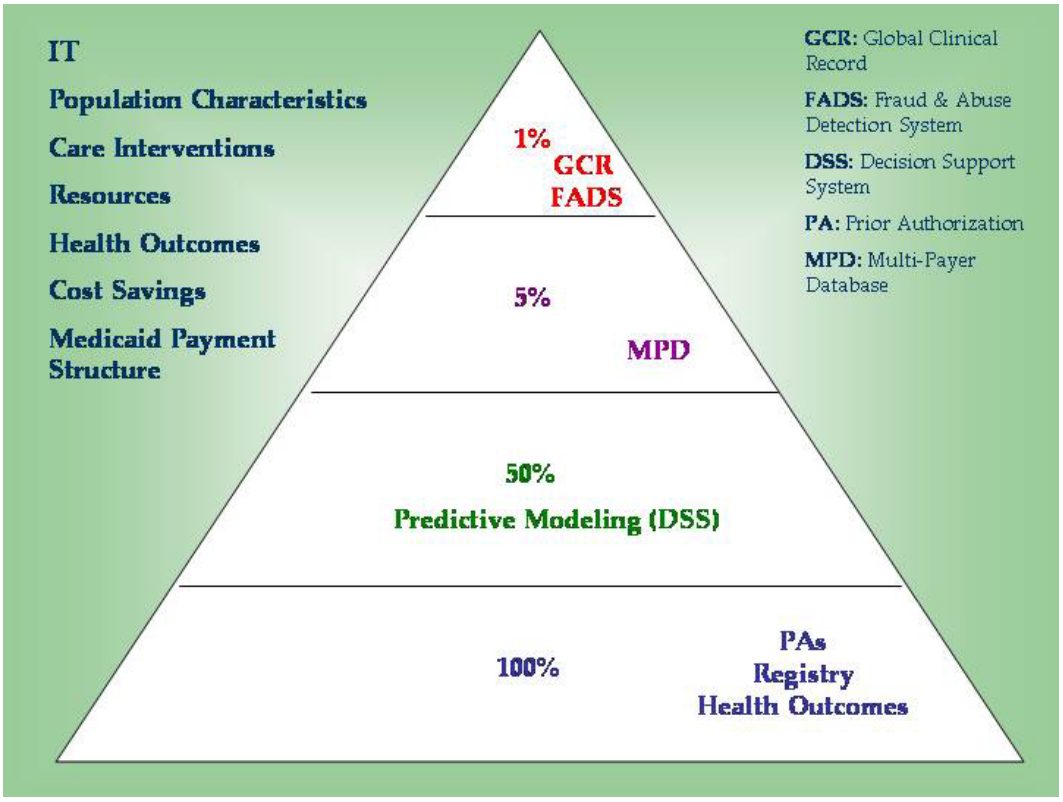
*CHCS, Environmental Scan: Health Supports for Consumers with Chronic Conditions; November 2005

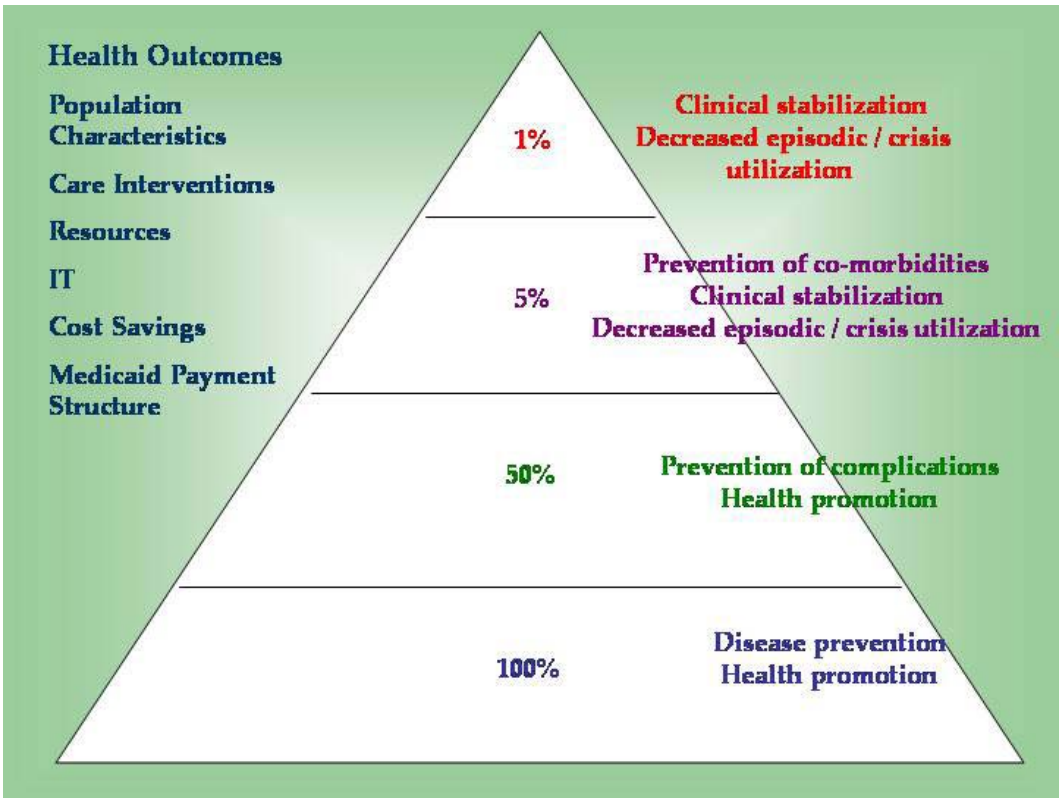

Percent of Population by Utilization
1%
5%
50%
100%

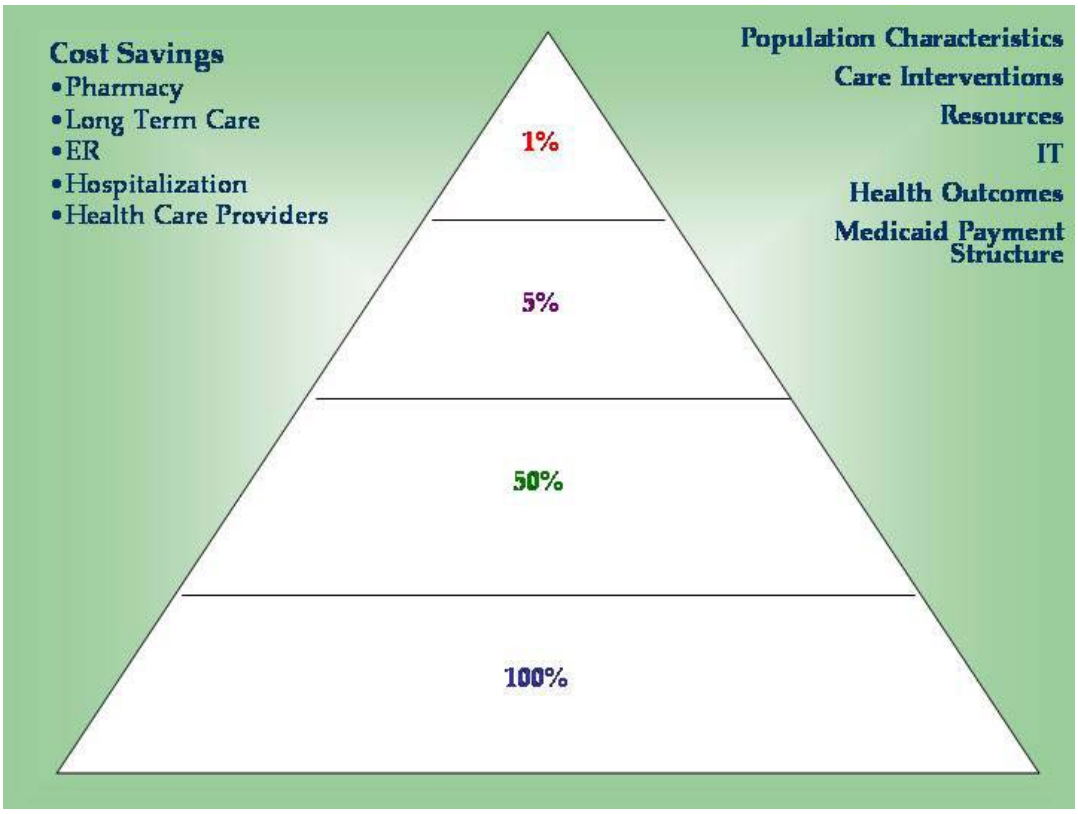

Population Characteristics
Care Interventions
Resources
IT
Health Outcomes
Cost Savings
Medicaid Payment Structure
1%
Multiple co-morbidities
High utilization
High prevalence of psych / substance abuse
5%
Chronic condition with complications
Special populations (Buprenorphine)
50%
Chronic condition without complications
100%
Behavioral or genetic risk factors for disease
No known chronic condition

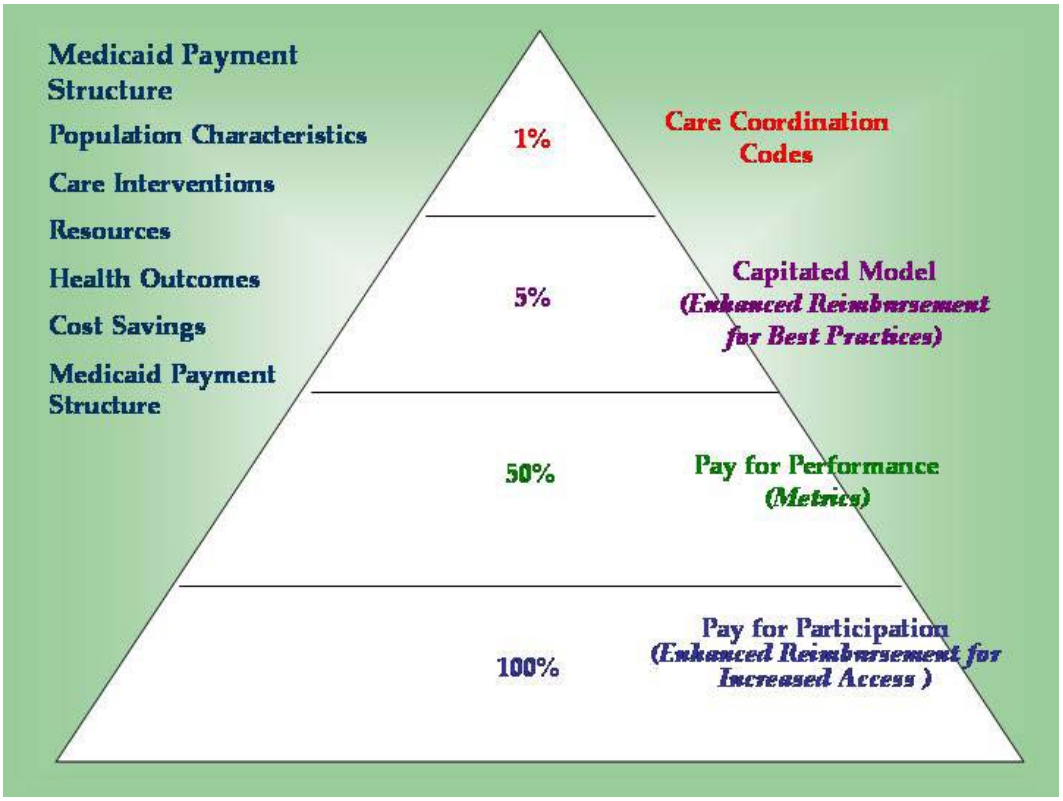

Care Intervention
Population Characteristics
Resources
IT
Health Outcomes
Cost Savings
Medicaid Payment Structure
1%
Intensive Care Coordination
(3-6 Months)
Patient Self-Management
5%
Co-management (RFP)
Patient Self-Management
50%
Blueprint Activities
Patient Self-Management
Disease Management
100%
Blueprint Activities

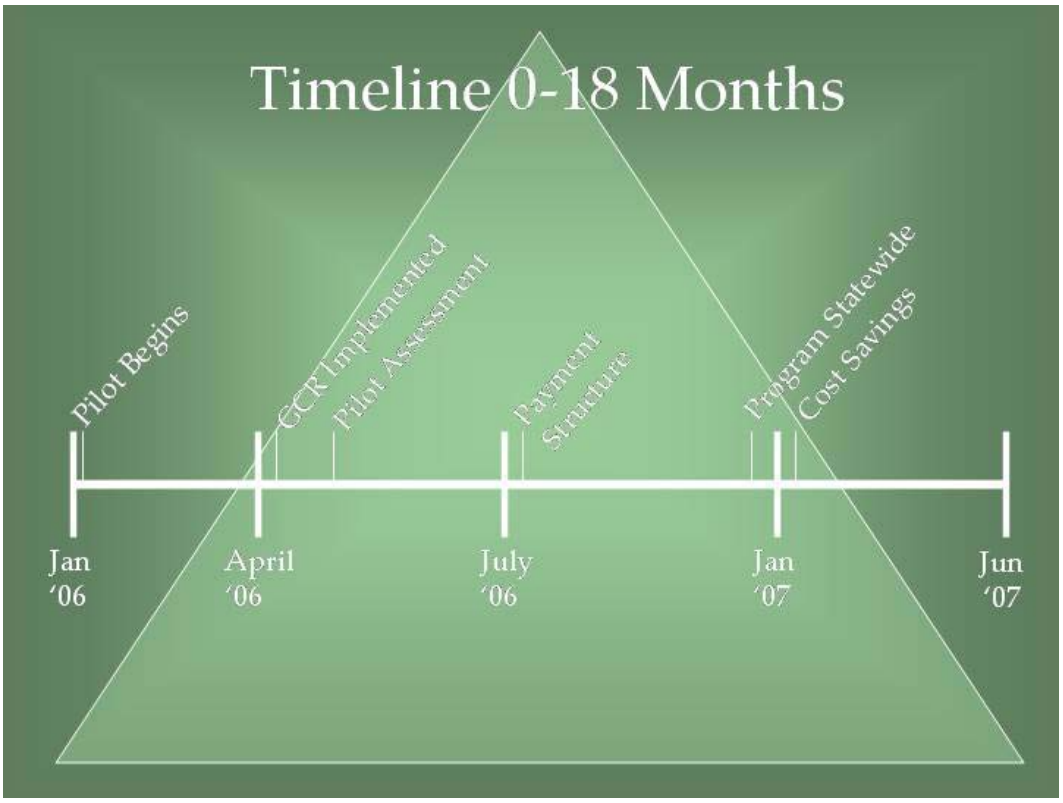

Resources
Population Characteristics
Care Interventions
IT
Health Outcomes
Cost Savings
Medicaid Payment Structure
1%
New Care Coordination Staff
Current SURS Team
5%
Current OVHA/AHS Staff
In-State Out-Sourcing
50%
Current OVHA
Staff/AHS/Blueprint Partners
100%
Current OVHA
Staff/AHS/Blueprint Partners


IT
Population Characteristics
Care Interventions
Resources
Health Outcomes
Cost Savings
Medicaid Payment Structure
1%
GCR
FADS
5%
MPD
50%
Predictive Modeling (DSS)
100%
PAs
Registry
Health Outcomes
GCR: Global Clinical Record
FADS: Fraud & Abuse Detection System
DSS: Decision Support System
PA: Prior Authorization
MPD: Multi-Payer Database


Health Outcomes
Population Characteristics
Care Interventions
Resources
IT
Cost Savings
Medicaid Payment Structure
1%
Clinical stabilization
Decreased episodic / crisis utilization
5%
Prevention of co-morbidities
Clinical stabilization
Decreased episodic / crisis utilization
50%
Prevention of complications
Health promotion
100%
Disease prevention
Health promotion


Cost Savings
•Pharmacy
•Long Term Care
•ER
•Hospitalization
•Health Care Providers
Population Characteristics
Care Interventions
Resources
IT
Health Outcomes
Medicaid Payment Structure
1%
5%
50%
100%


Medicaid Payment Structure
Population Characteristics
Care Interventions
Resources
Health Outcomes
Cost Savings
Medicaid Payment Structure
1%
Care Coordination Codes
5%
Capitated Model (Enhanced Reimbursement for Best Practices)
50%
Pay for Performance (Metrics)
100%
Pay for Participation (Enhanced Reimbursement for Increased Access)


Timeline 0-18 Months
Pilot Begins
GCR Implemented
Pilot Assessment
Payment Structure
Program Statewide
Cost Savings
Jan '06
April '06
July '06
Jan '07
Jun '07


Timeline 0-3 Months
•Commencement of Pilot Program: Identification of beneficiaries & collaboration w/providers in care plan implementation.
•5 staff hired: 2 Nurses and 2 Social Workers, 1 Field Director.
•1 Nurse and 1 Social Worker team will work in Caledonia county, and 1 Nurse and 1 Social Worker team will work in Washington county.
Jan '06
Feb '06
March '06
April '06


Timeline 3-6 months
GCR online:
• Case Tracking
• Establishing accounts for participating Primary Care Providers
• Training practices in use of GCR
Initial health outcomes from the pilot phase are analyzed.
April '06
May '06
June '06
July '06


Timeline 6-12 months
Program goes statewide.
Modifications as recommended by stakeholders are implemented.
Aug '06
Sept '06
Oct '06
Nov '06
Dec '06
Jan '07

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Expenses

Cost Benefit Analysis

EXPENSE	ANNUAL BUDGET TOTAL EXPENSE WITH FEDERAL MATCH	MATCH RATE	ANNUAL STATE DOLLARS
Personnel	$3,017,600	75/25	$754,000
Operating	$377,200	50/50	$188,600
TOTAL	$3,394,800		$943,000*
In SFY '06 only 1/2 (6 months) would be included @ $471,500.			

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Savings

- Medicaid expenditures for individuals with top five chronic illnesses exceeded $46 Million in FY '04.
- Typical saving in FL, NC, WA, IN, GA have averaged from 5% - 15%.
- Projected savings for Vermont:

  ($46,408,846 x 5%) = **$2,300,000.00**

  ($46,408,846 x 15%) = **$6,900,000.00**

**Actual savings in SFY '06 assume to be 25% of this amount @ $575,000.*

VERMONT

The Choice: Care Coordination

"Addressing this major root cause of Medicaid's burgeoning growth will result in a program that delivers increased value through improved health care quality and more effective targeting of resources for our nation's most vulnerable individuals, today and for future generations."

CHCS, Environmental Scan: Health Supports for Consumers with Chronic Conditions; November 2005

Appendix 12: ESI Legislative Report

General Overview

Act 71, § 299, passed during the 2004-2005 Vermont Legislative session, requires the Office of Vermont Health Access (OVHA) to report to the Health Access Oversight Committee, the Senate and House Appropriations Committees, the Senate Committee on Health and Welfare, and the House Committee on Human Services with "a plan for the employer-sponsored insurance program" (see Appendix B). In addition to presenting a plan, the legislation requested guidance on what is a minimum and affordable coverage, and the amount of subsidies to be offered.

On August 5, 2005, OVHA, in collaboration with the Department for Children and Families (DCF) and the Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), began work on a plan to develop a premium assistance program. The premium assistance program would provide subsidies for individuals applying for and enrolled in Medicaid that have employer-sponsored health insurance (ESI) available to them. This report is the culmination of that work. The report includes information on existing employer sponsored insurance options; recommendations for the subsidy amounts, the minimum health insurance coverage to be subsidized, the definition of "affordable" coverage; the estimated cost to administer the program, and a premium assistance program implementation timeline.

The program would require those adults in the VHAP program from 100% to 185% FPL who have access to employer sponsored insurance to take advantage of that coverage. Beneficiaries would pay no more than they presently pay for coverage. The minimum coverage would include the core services of inpatient, outpatient, pharmacy, and preventive care. While there is an initial investment and on-going administrative expenses, these costs should be offset by savings. The Governor's recommend has the program beginning January 1, 2007.

Assumptions and Definitions

The language in the bill states the program is for VHAP and Dr. Dynasaur individuals "who have employer-sponsored health insurance". This is interpreted to mean individuals who are currently enrolled, or new enrollees, in VHAP or Dr. Dynasaur with health insurance coverage available through the individual's or, in the case of minor children, the guardian's employer. Currently, no publicly-subsidized employer-sponsored health insurance program exists in Vermont.

Employer-sponsored insurance (ESI) is defined as any comprehensive group health plan that provides coverage to a Vermont resident (or the dependents of the Vermont resident, if applicable) under an insured or self-insured policy or plan issued to, or sponsored by an employer, including sole proprietors, or an authorized employer or employee association, trust or group. Source: 8 V.S.A. § 4079; ERISA, *Barron's Dictionary of Insurance Terms (Rubin, Third Ed. 1995).

Wraparound coverage means providing Medicaid benefits for services not covered by the insurance policy and/or for cost sharing.[5]

Under Medicaid, ESI without wraparound coverage may only be mandated for expansion groups because states are required to offer all traditional Medicaid recipients the same benefit package (42 USCA 1396a(a)(10)(B)), and most private insurance plans offer less comprehensive coverage than traditional Medicaid. In Vermont ESI, without wraparound coverage, may be mandated under existing rules for children with income between 225% and 300% of the federal poverty level (FPL) and uninsured adults with income below 150% FPL (See illustration in Appendix F).

The Federal SCHIP program, which supports 3,000 children between 225% and 300% FPL in the Dr Dynasaur program, allows for the implementation of a Premium Assistance program with some restrictions. A Premium Assistance program is defined by SCHIP as a component of a separate child health program, approved under the state plan which requires a state to pay part or all of the premiums for a SCHIP enrollee or enrollee's group health insurance coverage or coverage under a group health plan. SCHIP requires that the coverage offered through premium assistance be comparable to coverage offered by SCHIP. If the coverage is not comparable, then the state may have to provide wraparound coverage. SCHIP also restricts beneficiary total out of pocket expenses to 5% of family income for a year (CFR 42 § 457.450).

Self-insured plans are not subject to Vermont mandates and parity laws. Employer groups who choose to self-insure their group insurance product are not obligated to adhere to state-mandated benefits but may opt to as a courtesy to their employees. The U.S. Department of Labor, not the State of Vermont, has regulatory authority over these plans. Because these plans may not qualify as equivalent coverage compared to Vermont's Common Benefit Plans, and the lack of state regulation and data on these plans and their enrollees, we recommend the ESI program not include self-insured plans.

What We Know About ESI

Vermonters, like other Americans, obtain their health coverage from a variety of sources, including government programs (Medicare and Medicaid) and commercial health insurers. Of Vermont residents with health insurance, almost two out of three (64%) obtain health coverage through the private market, which includes insured group plans, insured non-group plans, and self–funded employer plans.[1] While Vermont has limited data in which to estimate who has access to employer-sponsored insurance, there are some data points to consider.

According to the 2005 Fringe Benefit Survey of the Vermont Department of Employment and Training, the overall offer rate for all private industry employers was 58%, with the rate rising to 88% or greater in firms with 20 or more employees. On average, Vermont employers that offer health insurance contribute a major portion of the total insurance

premium. Larger firms pay an average of about 80% of the cost of coverage with smaller firms paying a greater share.[2] OVHA could not identify any Vermont data on access to ESI by income. OVHA has found two published reports with national data on access rates. First, the National Academy for State Health Policy included the below table in a report on premium assistance. While the data is based on those who are uninsured, it provides some indication of the availability of ESI by income.[3] Secondly, the Kaiser Commission has reported that 41% of workers below the poverty level had access to ESI, while 62% of those between 100% and 199% had access.[4]

Percent of Uninsured People with Access to ESI by Family Income[3]

FPL	Children	Adult Parents	Adult Non-Parents
Less than 100%	23%	18%	7%
100 – 132%	40%	33%	9%
133 – 199%	55%	38%	15%
200 – 249%	63%	44%	26%
250 – 399%	51%	44%	27%

Source: IHPS Analysis of the 1996 Medical Expenditure Panel Survey

A comparison of three of the most commonly sold health insurance policies in Vermont demonstrates that the plans vary little in the benefits and coverage included. The deductibles, co-insurance percentages, co-pays and out-of-pocket maximums, however, vary widely (see Appendix C). BISHCA has determined that the average Vermont deductible and co-pay per person is $600 per year.

Other facts available from state and national data about these employers and the coverage they offer are:

- Large firms are more likely to participate, as the majority of children eligible for premium assistance will likely have parents working for large, not small, firms. Almost two-thirds (63%) of low-income uninsured children with access to ESI have a parent or parents working for a firm with 100 workers or more.
- Retail and professional services establishments may be more likely to participate as they employ the largest shares of uninsured workers (26% and 16%, respectively). Compared to other industries, however, retail establishments are less likely to offer insurance (75% of retail firms offer insurance coverage)[5]

Vermont's business market is made up of few large employers (51 or more employees) and is predominately made up with small employer groups (50 or fewer employees.) Therefore, the cost-effectiveness of the ESI program may produce lower numbers of participation due to the statistically lower premium contributions of small employers. The lower premium contribution of these employees results in the need for state contributions to significantly exceed the state costs per member per month for Dr. Dynasaur and VHAP.

According to the National Academy for State Policy, "Many states have expressed interest in pursuing premium assistance because they want to take advantage of the

contributions that employers make toward the cost of employee health insurance coverage. These states reason that the savings that will result from leveraging employer contributions can help address tight state budgets and provide a mechanism to cover a greater number of the uninsured population. Some states also place value on using the private sector to provide coverage, rather than expanding public programs. The potential to reduce state costs and cover more people is attractive; however, many factors affect how well premium assistance works in a given state. It is important that states carefully consider these factors when deciding to use premium assistance to provide coverage." [5] In February 2004, there were fourteen states with premium assistance programs in operation. These programs are operated through various mechanisms including under SCHIP, 1115 Research & Demonstration Waivers, Health Insurance Flexibility and Accountability (HIFA) Waivers under 1115 section authority, and under Section 1906 HIPP programs.[5]
Premium Assistance programs in the states serve different populations. Some examples are:

- New Jersey – 2001[3] – Families 200% & Children 300% - 729 enrolled[6]
- Oregon – 1998[3] – Children & Adults 185% FPL – 10,564 enrolled[6]
- Rhode Island –2002[3] – Adults 185% FPL, Children & Pregnant Women 250% - 6,012 enrolled[6]
- Utah – 2003[3] – Adults 150% FPL – 73 enrolled[6].

What is Affordable?

What is affordable to one person may or may not be affordable to another person. In order to address the question the first step is to decide on a methodology for determining affordability. The federal regulations for the SCHIP program require that total out-of-pocket expenditures (premiums, deductibles and co-pays combined) be no more than 5% of total income for a year. The use of out-of-pocket expenditures as a percentage of income (ability to pay) has also been used in defining those who might be underinsured.[7] This approach, taken in consideration with the benefit package, seems to be an acceptable methodology for assessing what is affordable coverage. In order to compare apples to apples, we are assuming that benefit packages will have coverage that is 'comprehensive' (i.e., include hospital, physician and pharmacy). Including premiums, deductibles and co-pays as total out-of-pocket expenses will take into account the fact that premiums may vary as will deductibles and co-pays. A plan with a low premium may have high deductibles and co-pays or a plan with a high premium may have low deductibles and co-pays, with all being included in the total out-of-pocket expenses.

As noted above, the Federal SCHIP program has restricted total out-of-pocket expenses to 5% of family income for a year. The Vermont SCHIP program ensures that total out-of-pocket expenses are less than 5% by charging an annual premium that is less than 5% of family income, with no co-pays or deductibles. In an article titled "Insured But Not Protected: How Many Adults Are Underinsured", the authors attempted to define who is underinsured by surveying over 3,000 adults. The person was considered underinsured if one of three indicators was present: (1) medical expenses

amounting to 10% of income or more; (2) among those low income individuals below 200% FPL, medical expenses amounting to at least 5% of income; or (3) health plan deductibles equaling or exceeding 5% of income.[7]

Seeking other guidance we looked to premium assistance programs operated by other states. Oklahoma has begun a new program where out-of-pocket cost for the beneficiary is capped at 3% of income. Oregon has a state-operated insurance product where a sliding scale based on income is used to determine the employee share. The Oregon beneficiary pays between 5% and 50% of the employees share of the premium depending on federal poverty level. Utah requires individuals to enroll in ESI unless the employee's share is 15% of their income.[6]

Act 71 in Section 117, the budget for the Office of Child Support, stated that "medical coverage is presumed to be available to a parent at a reasonable cost only if the amount payable for individual insurance or a health benefit plan premium is 5% or less of the parent's gross income."

To provide some perspective, the Table in Appendix F includes income levels, premiums and premiums as a percentage of income for those covered in OVHA programs. OVHA beneficiaries on average pay approximately 5% of income using federal poverty guidelines. Those paying the highest percentage of income were those in the VHAP program at incomes above 75% FPL. Those paying the lowest percentage of income were the very poor below 75 % FPL, and those families with children. Using 5% of income as a threshold for what is 'affordable' for low-income individuals (those below 185%) is consistent with present OVHA premiums.

What is Minimum Health Insurance Coverage?

A standard comprehensive policy in Vermont covers in-patient, out-patient, physicians and lab services. The Vermont Common Benefit Plan (BISHCA Regulation 91-4b and Bulletin 102) provides the basis for the minimum coverage requirements. All fully-insured small group plans in Vermont are required to provide benefits for mandated coverage. While on the surface little difference in coverage appears to be the case (See Appendix C) between VHAP, Medicaid/Dr. Dynasaur and commercial plans, there are some important differences.

Coverage for VHAP and Dr. Dynasaur are different. Coverage offered through ESI may be equivalent to VHAP in that 'core services' (inpatient, outpatient, pharmacy, and preventative care) are covered. Coverage offered through ESI for Dr. Dynasaur (children) may not be equivalent. If a child is still considered Medicaid-eligible under ESI, there are a number of questions about benefits that arise.

Currently the Medicaid mandate requires children get a full scope of preventive and remedial services irrespective of cost and scope under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Under ESI, it is not clear how the EPSDT mandate would coordinate with an employer plan, whose benefits may or

may not provide the same level of screening and preventive services under EPSDT. Some employer plans do not cover annual preventive adolescent visits. It is during these visits that screenings and assessments are a key contributor towards identifying risk factors or other health issues essential for proper and positive growth and development.

EPSDT-mandated services also include transportation and oral health services. Currently many employer plans do not cover routine (non-emergency) transportation services. In addition, many employers separate medical from dental benefits and see them as two different plans. If an employer only covers medical benefits, would an ESI child still be eligible for Medicaid dental benefits and would there be a premium? In addition, personal care services, currently offered under Dr. Dynasaur, are not a benefit under most employer sponsored coverage.

One option that state Medicaid programs have used to ensure comparable benefits to those in ESI is wraparound coverage. Wraparound can be used to maintain cost sharing within determined levels, or by covering services not covered through ESI. The state covers the costs for services not covered through ESI by providers billing Medicaid rather than the health plan. Using wraparound coverage is one method to ensure comparable benefits.

OVHA Premium Assistance Program Design

Enrollment

Who could be enrolled?

There are five populations that could be enrolled in ESI:

- Adults and children in Dr. Dynasaur (0% - 225%),
- Adults in VHAP (0% - 185%),
- Children in SCHIP (225% - 300%),
- Uninsured adults (0% - 185%), and
- Uninsured children (0% - 300%).

As noted earlier in this report, not all will have access to employer-sponsored coverage. The most optimistic estimate for adults was that 62% of adults between 100% and 199% FPL will have access to employer sponsored coverage. Adults from 0% to 100% FPL have low rates of access to ESI, which is in part is due to access to employer-sponsored coverage being more available as wages/income increase. Uninsured children could be included because access to ESI is higher than for adults in similar income brackets, although, the provision of wraparound coverage to ensure children have a comparable benefit may add challenges to implementation.

OVHA has no estimate of how many who have access would actually enroll due to a number of reasons. First, some will not meet the cost effectiveness test. Second, others may no longer choose to maintain coverage due to health status or value versus

costs. Third, others may drop coverage finding enrolling in ESI an added administrative burden.

OVHA plans to enroll those VHAP adults, and any new VHAP applicants, between 100% and 185% FPL.

How will they be enrolled?

Those new applicants who are eligible with access to ESI will be required to enroll. Those presently enrolled with access to ESI will be required to participate when they have a break in coverage and re-apply, or when their case is reviewed. Initially, all current VHAP enrollees 100% to 185% FPL would have their cases reviewed. OVHA will allow those eligibles with access to ESI to enroll voluntarily at any time.

Those eligible with access to ESI will be forwarded from DCF to OVHA for further processing. While eligible, coverage will not begin until a cost-effectiveness determination has been made. OVHA will mail a questionnaire to the employer to confirm the person's employment, and the required information about the insurance coverage that the employer offers. Once the information is received, OVHA will make a cost-effectiveness determination. If the individual meets the cost-effectiveness test (benefits, costs, etc.) then coverage would be available once enrolled in their employer-sponsored plan. A notice will be sent to the employer announcing the applicant's eligibility for ESI. The notice will also indicate the amount that OVHA will be subsidizing toward the employee's coverage. Coverage will not begin until the month after all necessary information is returned and processed. OVHA will need ongoing information to confirm continued employment and participation in their employer's sponsored coverage.

Reports from other states that have an ESI program indicate that the most critical part of the enrollment process is the gathering of information from employees and employers regarding the group health insurance plan offered. The program will not succeed unless employer coverage can be verified and the necessary plan information obtained.[1] Legislation to mandate cooperation in returning the OVHA questionnaire within a specified timeframe (10 days), or building incentives for employers to respond, would be critical to the program's success.

Premiums: Participants in the premium assistance program will pay a premium to OVHA as do others in the VHAP program.

Coverage: The coverage offered under ESI for adults will provide core services (inpatient, outpatient, pharmacy, and preventative care). If benefit coverage is not comparable, OVHA may provide wraparound coverage or not require enrollment in ESI.

Subsidies: OVHA recommends that beneficiaries pay no more of their income than they presently pay when participating in the premium assistance program. Thus, subsidy amounts will vary depending on federal poverty level, premium cost, and other out of

pocket expenses (see Appendix D). Subsidies cannot be greater on average than what OVHA would spend on providing care directly.

Individual Cost Effectiveness Test: OVHA can use upgraded technology currently available through the MMIS to assess whether or not it is cost-effective to subsidize the health insurance premium for our beneficiaries. If it is, they will be required to participate in the premium assistance program. The information will include employee share of the premium and the total out of pocket maximum requirement that must be met by the employee to determine cost effectiveness and the amount that OVHA will be asked to contribute in support of the health insurance coverage.

In order to determine the cost effectiveness of enrollment, the Medicaid Management Information System (MMIS) will need to be updated to include the applicant's annual income, employer, and health plan. From this information, a calculation will be performed that will determine the dollar amount that the employee should contribute towards their health insurance premium. A comparison will be performed comparing the average annual "PMPY" (per member per year) to the annual cost of the premium plus the out of pocket maximum. If the premium plus out of pocket maximum is less than the annual per member per year (PMPY), we would require this applicant to enroll in the premium assistance program.

In order to help us understand the financial implications, including subsidy amounts and affordable coverage, the group evaluated the program design for different scenarios. The scenarios included variable insurance premium information, coverage, family size, income(s), type of insurance plan and employee out-of-pocket maximums. Scenario variations are based on employer size or employee share and what Medicaid would cover (see Appendix D). Issues with implementing a premium assistance program in Vermont arose as the scenarios were developed. These issues include the wide variations in employer-sponsored health plan employer/employee splits, co-payments and co-insurance, deductibles, out-of-pocket maximums, plan limitations, and the variance in co-payments for services from in-network and out-of-network providers. Additionally, determining how and if an employer-sponsored insurance plan could be implemented for self-insured plans, for which the state of Vermont does not have any regulatory authority, proved problematic.

As you can see from the tables in Appendix D, when premiums are low ($350.00 - $450.00 per month) and out of pocket expenses are average ($600 per year) or slightly above average ($1000) then ESI is cost-effective in most cases. As premiums rise to $550 and above per month, it is only cost-effective with 80/20 or 70/30 employer/employee splits with average out-of-pocket expenses.

Operational Issues

In order to operationalize an employer-sponsored health plan, OVHA would need to undertake a number of activities including outreach to employers and beneficiaries; changes to policies, application forms, eligibility review processes, and computer

programming; and approvals from CMS as needed. Implementation will be challenging due to the complexity of this effort (see Appendix E).

All current VHAP enrollees and new applicants would have to be reviewed and employers contacted to determine the level of employer/employee cost sharing. As shown by the above examples, cost effectiveness will need to be determined on a case-by-case basis as health coverage costs and employer/employee share will vary. Once enrolled in the premium assistance program and covered by the employer, the beneficiary or employer would need to submit information to OVHA at regular intervals (at a minimum annually upon the plan's annual anniversary date) that confirms participation.

States with employer-sponsored insurance plans have found varying degrees of employer responsiveness when requesting information to confirm employment, determine employer/employee share, costs of health coverage, and the extent of the coverage (inpatient, outpatient, dental, pharmacy). In order for the program to succeed, cooperation and assistance from employers may need to be required.

Some employers offer ESI coverage to the whole family, but will only contribute the employer share for the employee and not for any other family members. For example, an employee with a spouse may be able to enroll their spouse in ESI only if the employee pays 100% of the additional costs. In those instances it is doubtful it would be cost-effective.

One significant challenge to enrolling those eligible for the OVHA premium assistance program is access to ESI coverage once they are determined eligible. Many of the commercial health plans restrict open enrollment to January and February. Thus, a person determined eligible in May could not enroll and be covered by their employer until January – eight months later. Vermont statute allows individuals to enroll in employer-sponsored coverage when determined eligible under what is considered a 'qualifying event'. A statutory change to 8 V.S.A. § 4090 a-c, Vermont's continuation provisions, would be needed to allow eligibility for the OVHA premium assistance program to be considered a qualifying event.

Another consideration is whether or not employers might move to policies that are less expensive (less coverage) or those with high deductibles. We might find that businesses provide less coverage because of the additional cost if more employees join their plan. It would be hard to put a cause and effect to any change in policies because employers may raise premiums or deductibles. Market effects could also be driving changes. The employers participating would have to agree to make any changes to the current offered health insurance coverage only at the annual anniversary date of the current plan. Employers would also have to agree to share plan changes with OVHA in order to determine continued cost-effectiveness of the ESI program for individual employees.

Administrative Cost Estimate

The enrollment of those estimated 6,000 currently enrolled individuals eligible for ESI should generate savings of $5.8 million. The Governor's recommend includes funding for an additional 6,000 uninsured Medicaid eligible individuals who would enroll. The start-up activities required for a premium assistance program would include changes to application forms; changes to the computer programming in ACCESS and the MMIS; changes to beneficiary notices; the design and printing of beneficiary and employer materials describing the program; outreach to beneficiaries and employers; and systems to transfer subsidies. The most significant ongoing administrative activity would be the on-going need to confirm and re-confirm employment information, health coverage, and employer contribution.

One time programming that will be needed in the ACCESS and the MMIS Systems is estimated to cost $1,220,000. The program would require $150,000 to outreach employers. OVHA estimates that six additional staff will be needed to process applications of those eligible with access to ESI, and to assess for cost effectiveness. Existing OVHA staff (clinical, policy, financial, etc.) will provide support to the premium assistance program as required.

Conclusions

The implementation of a premium assistance program to provide subsidies to individuals (and families) who have access to ESI presents many challenges to beneficiaries, employers, health plans, DCF and OVHA. While initial start-up costs are significant, the estimated cost savings generated through premium assistance should make it worth the investment and effort to enroll those in VHAP. The Governor recommends includes an option to provide premium assistance to those uninsured between 150-300% FPL. As individuals move up the income scale ESI is more likely to be available, and subsidies may be the incentive for those who are employed and remain uninsured.

Appendix A: References

1. Department of Banking, Insurance, Securities, and Health Care Administration, Health Insurance Coverage Profile of Vermont Residents 1997-2004. http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/profile_1997to2004.pdf

2. Vermont Department of Labor; Survey of Fringe Benefits in Vermont 2005. http://www.vtlmi.info/fringebene.pdf

3. Williams, C., A Snapshot of State Experience Implementing Premium Assistance Programs. National Academy for State Health Policy, April 2003.

4. Kaiser Commission on Medicaid and the Uninsured. Serving Low-Income Families Through Premium Assistance: A Look at Recent Activity. October 2003.

5. NASHP Website http://www.patoolbox.org/

6. Akler, J., Premium Assistance Programs: How are they financed and do states save money? Kaiser Commission on Medicaid and the Uninsured. October 2005.

7. Schoen, C. et al. Insured But Not Protected: How Many Adults Are Underinsured. Health Affairs Web Exclusive; June 14, 2005

Appendix B – The Law

Act 71 - Sec. 299. Employer Sponsored Insurance

(a) The office of Vermont health access with the assistance of the department of banking, insurance, securities and health care administration shall develop a program to provide subsidies for individuals applying for and enrolled in the Vermont health access program and the Dr. Dynasaur program who have employer sponsored health insurance. The office and department shall report to the health access oversight committee, the senate and house appropriations committees, the senate committee on health and welfare and the house committee on human services with a plan for the employer-sponsored insurance program no later than January 15, 2006. The plan shall include recommendations for the subsidy amounts to be provided for each program by relevant income amounts based on federal poverty level, administrative cost estimates, implementation timelines, existing employer sponsored insurance options, a recommendation on the minimum health insurance coverage to be subsidized, and a recommendation on how to define "affordable" coverage for individuals, families and children by relevant income amounts based on federal poverty level.

Appendix C - Plan Comparisons

Plan Comparison

Type of Services	VHAP	MEDICAID/ Dr Dynasaur	MVP HMO 15	CIGNA PPO	BCBS Plan
Ambulance/Medical Transportation	X*				
Chiropractic Benefit		X**	X	X	X
Dental Services		X	X	X	X
DME/DMS	X	X	X	X	X
Emergency Hospital Care	X	X	X	X	X
Home & Community-Based Health Care Services		X	X	X	X
Inpatient MHSA	X	X	X	X	X
Inpatient Services	X	X	X	X	X
Lifetime MaXimum Benefit			X 2 million	X 2 million	X 2 million
Outpatient MHSA	X	X	X	X	X
Outpatient Services	X	X	X	X	X
Physical Therapy	X	X	X	X	X
Physicians Services	X	X	X	X	X
Prenatal Care and Pre-pregnancy Family Services	X	X	X	X	X
Prescription Drugs	X	X	Rider	X	X
Transplant Services	X	X	X	X	X
Vision	X No Eyeglasses	X**	X Limited	X Limited	X Limited

* Only ambulance: non-emergency transportation is not included.
** Only children.

Plan Name: CIGNA PPO 250 Plan Premium = $X00.00

Calendar Year Deductible		**Out-Of-Pocket Limit**	
Individual	$250	Individual	$1,500
Family	$500	Family	$3,000

Type of Service	**Co-Pay**	**Benefit Limit**
Physician Services	$15.00	
Preventative Care		
Routine Preventative Care	$15.00	
Well Woman Care	$15.00	
Mammogram	N/C	
Inpatient Hospital		
Inpatient Doctor Hospital		
Outpatient Surgical Facility		
Outpatient Surgery		
Emergency Care		
Doctor's Office		
Emergency Room	$15.00	
Skilled Nursing Facility		
Lab & X-Ray Services		
Outpatient Short-Term Rehab		
Facility/Hospital Outpatient		
Doctor's Office		
Home Health Care		
(Up to 40 visits per Calendar Year)		
Hospice		
Maternity		
Initial Visit to confirm Pregnancy		
Delivery Charge/Including Pre & Post Natal Visits		
Lifetime Maximum		Unlimited
Organ Transplants		
DME		
External Prosthetic Devices		
Mental Health		
Inpatient		
Outpatient		
Substance Abuse		
Inpatient		
Outpatient		
Prescriptions Drugs (Rx Prime) (30 Day Supply)		
Mail Order Drugs (TelDrug) (90 Day Supply)		
Routine Vision		Same In or Out of Network

Plan Name: BCBS Comprehensive Plan Premium = $X00.00

Calendar Year Deductible		**Out-Of-Pocket Limit**	
Individual	$3,000	Individual	$3,000
Family	$3,000	Family	$3,000

Type of Service	**Co-Pay**	**Benefit Limit**	
Physician Services	0%		
Office Visits	0%		
Laboratory Services	0%		
Hospital Services	0%		
Hospital			
Hospital Inpatient	0%		
Hospital Outpatient-Surgery	0%		
Hospital Outpatient-Lab & X-Ray	0%		
Hospital Outpatient-Therapeutic Srvs	0%		
Maternity	0%		
Emergency Hospital Care			
In-Area	0%		
Out-of-Area	0%		
Ambulance	0%		
Dental	0%		
Chiropractic Benefits	0%		
Durable Medical Equipment	0%		
Mental Health/Substance Abuse			
Inpatient	0%		
Outpatient	0%		
Physical Therapy	0%		
Home Health Care	0%		
Lifetime Maximum Coverage		$2,000,000.00	Excludes Transplants

Plan Name: MVP HMO 15 Premium = $X00.00

Cost of Insurance Premium	Employer Share	Employee Share	% of Income

Type of Service	CoPay	Benefit Limit
Physician Services		
Office Visits	$15/Office Visit	
Laboratory Services	No Charge	
Hospital Services	No Charge	
Hospital		
Hospital Inpatient	$240 Copay/Admission 20% or $100	
Hospital Outpatient-Surgery	Copay/Visit	
Hospital Outpatient-Lab & X-Ray	No Charge	
Hospital Outpatient-Therapeutic Services	$15 Copay/Visit	
Maternity	No Charge	
Emergency Hospital Care		
In-Area	$50/Office Visit	
Out-of-Area	No Charge	
Ambulance	No Charge	
Preventative Dental care for Kids	$10/Office Visit	
Chiropractic Benefits	$15/Office Visit	
Durable Medical Equipment	20% Copay	
Mental Health/Substance Abuse		
Inpatient	No Charge	
Outpatient	$15/Office Visit	
Physical Therapy	$15/Office Visit	
Home Health Care	$15/Office Visit	
Lifetime Maximum Coverage		No Maximums

Appendix D - Cost Effectiveness Scenarios

Premium Per Month **$350.00**

ADULTS	FPL	Monthly Income	Out of Pocket - ***$600***	*Required Subsidy*	Out of Pocket - ***$800***	*Required Subsidy*	Out of Pocket - ***$1000***	*Required Subsidy*	***OVHA PMPM***
Single	100 - 150%	$798.00	$120.00	*$120.00*	$136.67	*$136.67*	$153.33	*$153.33*	$238.00
80/20 Split	151 - 185%	$1,197.00	$120.00	*$120.00*	$136.67	*$136.67*	$153.33	*$153.33*	$238.00
Single	100 - 150%	$798.00	$155.00	*$155.00*	$171.67	*$171.67*	$188.33	*$188.33*	$238.00
70/30	151 - 185%	$1,197.00	$155.00	*$155.00*	$171.67	*$171.67*	$188.33	*$188.33*	$238.00
Single	100 - 150%	$798.00	$190.00	*$190.00*	$206.67	*$206.67*	$223.33	*$223.33*	$238.00
60/40 Split	151 - 185%	$1,197.00	$190.00	*$190.00*	$206.67	*$206.67*	$223.33	*$223.33*	$238.00

Subsidy #'s in *italics* indicates it is cost effective.
Out of pocket = Employees Share + Average Co-pays & Deductibles

Premium Per Month **$450.00**

ADULTS	FPL	Monthly Income	Out of Pocket - ***$600***	*Required Subsidy*	Out of Pocket - ***$800***	*Required Subsidy*	Out of Pocket - ***$1000***	*Required Subsidy*	***OVHA PMPM***
Single	100 - 150%	$798.00	$140.00	*$140.00*	$156.67	*$156.67*	$173.33	*$173.33*	$238.00
80/20 Split	151 - 185%	$1,197.00	$140.00	*$140.00*	$156.67	*$156.67*	$173.33	*$173.33*	$238.00
Single	100 - 150%	$798.00	$185.00	*$185.00*	$201.67	*$201.67*	$218.33	*$218.33*	$238.00
70/30	151 - 185%	$1,197.00	$185.00	*$185.00*	$201.67	*$201.67*	$218.33	*$218.33*	$238.00
Single	100 - 150%	$798.00	$230.00	*$230.00*	$246.67	$246.67	$263.33	$263.33	$238.00
60/40 Split	151 - 185%	$1,197.00	$230.00	*$230.00*	$246.67	$246.67	$263.33	$263.33	$238.00

Subsidy #'s in *italics* indicates it is cost effective.
Out of pocket = Employees Share + Average Co-pays & Deductibles

Premium Per Month **$550.00**

ADULTS	FPL	Monthly Income	Out of Pocket - *$600*	*Required Subsidy*	Out of Pocket - *$800*	*Required Subsidy*	Out of Pocket - *$1000*	*Required Subsidy*	***OVHA PMPM***
Single	100 - 150%	$798.00	$160.00	*$160.00*	$176.67	*$176.67*	$193.33	*$193.33*	$238.00
80/20 Split	151 - 185%	$1,197.00	$160.00	*$160.00*	$176.67	*$176.67*	$193.33	*$193.33*	$238.00
Single	100 - 150%	$798.00	$215.00	*$215.00*	$231.67	*$231.67*	$248.33	$248.33	$238.00
70/30	151 - 185%	$1,197.00	$215.00	*$215.00*	$231.67	*$231.67*	$248.33	$248.33	$238.00
Single	100 - 150%	$798.00	$270.00	$270.00	$286.67	$286.67	$303.33	$303.33	$238.00
60/40 Split	151 - 185%	$1,197.00	$270.00	$270.00	$286.67	$286.67	$303.33	$303.33	$238.00

Subsidy #'s in *italics* indicates it is cost effective.
Out of pocket = Employees Share + Average Co-pays & Deductibles

Appendix E - OVHA Premium Assistance Program Implementation Timeline

Work to implement should begin on 4/1/06 to begin enrolling on 1/1/07.

Date	Task
Week 1	Workgroup meetings to develop system specifications, program details, operational plan, rule requirements, state plan changes, and any needed federal permissions.
Week 2	Begin drafting rules and operational plan
Week 4	Draft Scope of work for MMIS and ACCESS changes. Develop plan for outreach to beneficiaries and employers. Begin work on changes to application forms. Contact CMS, if needed, regarding changes to program.
Week 7	Staff policy changes internally to AHS, DCF/ESD, BISHCA, OVHA
Week 11	Staff draft rules to legislative committees, Medicaid Advisory Board Contract's for MMIS and ACCESS system changes in place. Draft forms circulated for review.
Week 13	ICAR filing on signature route.
Week 15	Pre-file rule with ICAR
Week 17	Proposed rule on signature route (after ICAR)
Week 18	File proposed rule
Week 22	Public hearing on proposed rule.
Week 24	Comments on proposed rules due Outreach letter to employers
Week 26	Final proposed rule on signature route Outreach letters to beneficiaries
Week 28	File final proposed rule (allowing 45 days for LCAR to meet) System changes in ACCESS And MMIS tested.
Week 34	Adopted rule on signature route Application forms distributed. Staff Training
Week 36	File adopted rule
Week 38	Effective date Notices to beneficiaries

Appendix F – Monthly Income and OVHA Premiums

FPL	Income	Program Fee	Program Fee as % of Income
50%	$399.00	$11.00	2.80%
75%	$599.00	$11.00	1.80%
75%	$599.00	$39.00	6.50%
100%	$798.00	$39.00	4.90%
100%	$798.00	$50.00	6.30%
150%	$1,197.00	$50.00	4.20%
151%	$1,197.00	$75.00	6.30%
185%	$1,476.00	$75.00	5.10%
186%	$1,476.00	$30.00	2.00%
225%	$1,795.00	$30.00	1.70%
226%	$1,795.00	$80.00	4.50%
300%	$2,393.00	$80.00	3.30%

Appendix G - Medicaid Coverage Groups for Children and Families